PLAINTIFF'S MOTION
EXHIBIT 27
Part 1

THE JAMAICA HOSPITAL

INFORMATION IN THIS RECORD IS CONFIDENTIAL
DO NOT REMOVE FROM HOSPITAL

IMPORTANT

1. Information in this record may not be released without approval of Medical Record Department
2. Medical Records must be available at all times. Do not leave In Drawers, Cabinets, etc.
3. Return Medical Records promptly to Medical Record Department

ALLERGIC TO

2014	2013	2012	2011	2010	2009	2008	2007	2006	2005
					6				

PATIENT NAME Aldwin Schaal Craft
FIRST MIDDLE LAST

PLAINTIFF'S EXHIBIT 69 2/11/14 MDA

Patient Fact Sheet

Name and Address
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Phone: (718)570-6224 **Sex:** M
SS No: 469-97-6997 **Marital Status** S
Race: W **Religion:** NO
BirthDate: 6/21/1975 **Occupation:**
Patient's Maiden Name:

Employer
UNKNOWN
Phone: (999)999-9999

Nearest Relative
SCHOOLCRAFT, SELF
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone: (718)570-6224 **Rel:** 09
Business Phone:

Admission Data

Account Number	Unit Number
130381874	1298984

Admit Date	Admit Time	ER MD
11/1/2009	8:54	-BERNIER

Triage Time	Prim Care MD
	NA

Guarantor
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone (718)570-6224
Business Phone
Rel: 01 **SS:** 999-99-9999
Occ:
Employer UNKNOWN

Emergency Contact
SCHOOLCRAFT
Home Phone: (718)570-6224 **Rel:** 01
Business Phone:

Insurance Information
Ins: AETNA US HEALTHCARE **Insured:** SCHOOLCRAFT, ADRIAN
Policy Number: BBM6PBBA **Group Number:** US008041009001 **Rel:** SELF/
PO BOX 981109
EL PASO TX 799981109
Phone Number (800)451-8843 **FIN** 19
Auth Number PENDING

Patient Name SCHOOLCRAFT, ADRIAN

Medical Record No. 1298984

Account Number 130381874

Date 11/1/2009

ID 130381874

Jamaica Hospital Medical Center

Emergency Department Record

History of Present Illness KTA

34 Year Old Male Patient Presents with Paranoid. see psychiatric assessment..

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU	Neuro	ENT	Resp	Musculoskeletal	Hematologic/Lymphatic
Skin	Psych	Heart	GI	Endocrine	Allergic/Immunologic
☐ All other ROS negative				Constitutional Sxs	Eyes

☐ Vital Signs/Triage/Nursing Notes Reviewed and Agree ☐ Hx unobtainable due to Tx urgency or poor historian(s) ☐ Additional Information from Police, Ambulance, Nursing Home or Relatives ☐ Old Medical Records Reviewed

Past Medical History ☑ No Relevant PMHx ☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA

Other PMHx ☐ Diabetes ☐ HTN ☐ Psychiatric ☐ Renal ☐ Seizures

Social History ☑ No Relevant SoHx ☐ ETOH ☐ Drugs ☐ Smoking Additional Sx

Family History ☑ No Relevant FmHx No Significant FMHx

Physical Exam

Exam Time

General Appearance

HEENT

Chest

Abdomen

GU

Extremities

Neuro

Skin

Back

Neck

Lymphatics

Patient Name SCHOOLCRAFT, ADRIAN Medical Record No. 1298984

Account Number 130381874 Date 11/1/2009

Diagnostics

Specimen Collected / ECG /Rad Ordered

MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
KTA	11/1/2009 12:59	Urinalysis	Status-Cancelled - Patient Discharged			
KTA	11/1/2009 12:59	Urine Tox	Status-Cancelled - Autocancel by LIS-not coll/rcv			
KTA	11/1/2009 12:59	CBC	Status-Interim	KTA		
KTA	11/1/2009 12:59	THC (MARIJUANA)	Status-Cancelled - Autocancel by LIS-not coll/rcv			
KTA	11/1/2009 12:59	Head CT s contrast	CTH-- DEPARTMENT OF RADIOLOGY Patient Name: SCHOOLCRAFT, ADRIAN MRN #: 001298984 Patient Loc: MENTAL HEALTH ER Requested by: Staff, Physician Exam: CT head w/o Result Date/Time: 11/02/2009 10:45 AM Radiologists: Janczuk, Peter MD ---------- Clinical indication: FIRST PSYCHOTIC EPISODE: RULE OUT LESION/MASS. NONCONTRAST HEAD CT. * NO ACUTE INTRACRANIAL HEMORRHAGE, no discrete lesions, no mass effect or abnormal intra-or extra-axial fluid collections. VENTRICLES and CISTERNS have NORMAL size and position. OSSEOUS STRUCTURES are UNREMARKABLE without definite acute or displaced fractures or discrete lesions. PARANASAL SINUSES and MASTOID CELLS are CLEAR without fluid or significant mucosal thickening.	SPU		
KTA	11/1/2009 12:59	TSH	Status-Interim	KTA		
KTA	11/1/2009 13:00	RPR	Status-Interim	KTA		
BWO	11/1/2009 13:50	Pulse Ox			BW	13:50

Recommended LOS/CPT/ICD-9 Code

Physician's LOS =

Nurse's LOS =

Diagnoses

Paranoid	297.9 ICD-9

	MD	MD Time	RN	RN Date/ Time	Admit to
Disposition					
Condition					

Physician (Print) Tariq, Khwaja (MD)

Physician Signature

Other Physicians

Tariq, Khwaja (MD)-Peteru, Sachidanand (Psychosomatic Fellow)

Patient Name **SCHOOLCRAFT, ADRIAN**

Medical Record No. **1298984**

Account Number **130381874**

Date **11/1/2009**

Primary RN (Print) Calise, Michael (RN CM)

Other Nurses

Chen, Karen (RN)~Woodruff, Brian (RN)~Okuwobi, Bukunola (LPN)~Brady, Odette (RN)~Moonsammy, Victor (RN)~Calderone, Virnalyn (RN)~Harper, Wendell (LPN)~Mero, Monica (Amb Care Rep)~Basi, Susheela (RN)~Calise, Michael (RN CM)~Arias, Carielys (Reg)~Boswell, Gwendolyn (RN)~Stancu, George (Clerk)

This chart has been electronically signed via the EmpowER software.

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381874** Date **11/1/2009**

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEntered: 11/1/2009 16:39 Vitals Taken By: BOK

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 99.2	Right	81	R 112	18		No Pain
T	Left		L 60			
R						

TimeEntered: 11/1/2009 17:00 Vitals Taken By: BOK

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 99.2	Right -	81	R 112	18		No Pain
T	Left		L 60			
R						

TimeEntered: 11/2/2009 6:26 Vitals Taken By: WHA

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 98.4	Right	90	R 123	20		No Pain
T	Left		L 73			
R						

TimeEntered: 11/2/2009 10:51 Vitals Taken By: KCH

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 98.6	Right	88	R 127/63	18	100%	No Pain
T	Left		L			
R						

TimeEntered: 11/2/2009 21:24 Vitals Taken By: BOK

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 99.2	Right	93	R 124	18		No Pain
T	Left		L 76			
R						

TimeEntered: 11/3/2009 6:29 Vitals Taken By: VMO

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 97`4	Right	86	R 124\60	18		No Pain
T	Left		L			
R						

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381874** Date **11/1/2009**

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEntered: 11/3/2009 10:52 **Vitals Taken By:** GBO

Temperature		Pulse		Blood Pressure		Respirations	Pulse Ox	Pain Scale
O	99.2	Right	90	R	123/68	18		No Pain
T		Left		L				
R								

Patient Name SCHOOLCRAFT, ADRIAN Medical Record No. 1298984

Account Number 130381874 Date 11/1/2009

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

Nursing Notes

Time Note Entered		RN Initials	Note
11/1/2009	13:51	BWO	Client is a 34 year old White male police officer who was BIB/NYPD in handcuffs after he was apprehended at his home. Client had an argument with his supervisor and then left the job, went home and barricaded himself in his apartment refusing to come out. Client failed his psychological exam at work one year ago and his gun was taken away. Client is reported to be paranoid believing that he has documentation to prove that his superiors are falsifying crime statistics inorder to garner promotions. Client also believes that his superiors are out to get him. Denies medical/ psych Hx. In control at this time. Will continue to monitor.
11/1/2009	15:38	BOK	pt received on bed, awake and relaxing,pt spoke to his father on phone. Pt denies suicidal or homicidal ideation safety environment maintained will continue to monitor pt
11/1/2009	20:11	BOK	pt ate 100% of dinner with no sign of distress noted
11/1/2009	22:56	BOK	pt awake on bed and relaxing, pt denies suicidal or homicdal ideation .safety environment maintained will continue to monitor
11/2/2009	0:03	VMO	Received pt in bed asleep side\ rails up no sign\ symptoms of distress for hold\ stabilize
11/2/2009	5:52	VMO	remains asleep in bed no sign\ symptoms of distress continue to monitor
11/2/2009	6:25	VMO	Pt awake in bed slept well v\s stable denies suicidal\ homicidal ideation calm in control little interaction for hold\ stabilize
11/2/2009	8:23	KCH	Received pt in lounge, sitting, calm and cooperative. No sign of acute physical distress noted. No respiratory distress noted. Emotional support maintained. Encouraged pt to verbalize feelings and thoughts. Safety maintained. Will continue to monitor pt's behavior.
11/2/2009	10:47	KCH	Pt is in bed, awake. Calm and cooperative.No sign of acute physical distress noted. No complaint offered. Ate meal with good appetite. Able to approach staff with needs. Pt is for hold in Er. Safety maintained.
11/2/2009	13:15	KCH	Pt is in bed, awake. Calm and cooperative. No sign of acute physical distress noted. No respiratory distress noted. Ate meal with good appeitite. Pt is for hold in Er. Safety maintained.
11/2/2009	16:06	BOK	pt received on bed, awake and relaxing, pt denies suicidal or homicidal ideation safety environment maintained will continue to monitor
11/2/2009	18:10	BOK	pt calm and quiet, pt 100% of dinner with no sign of physical distress noted
11/2/2009	22:43	BOK	pt in the lounge area watching tv and pt denies hallucination or delusion safety environment maintained will continue to monitor pt
11/3/2009	0:02	SBA	Received the pt asleep in bed,easily arousable. Not in distress. Pt was seen by family practice MD, and has been medically cleared for inpt admission. Needs financial clearance. Observation continued.
11/3/2009	3:00	SBA	Pt is seen sleeping in bed;easily arousable. No distress noted. Observation continued.
11/3/2009	6:10	SBA	Pt slept well during night. He is awake now,seen him writing something. Denies any physical complaints. Denies any suicidal/homicidal ideation.Has been calm and pleasant. Pt is for inpt admission,pending financial clearance.
11/3/2009	8:27	MC6	Pts. Report received from nite shift there is no behavioral changes noted at this time. He is found awake and seated in dayroom alert,responce and verbal torward staff. He has refused assistance from NYPD at this time. Requesting admission here at jamaica . He denies h/s ideations at this time. His appearence : good ADLs good, behavior even mannered verbal rate normal and volume nomal, contant approiated.Cognitive:preoccupied with curerent situation and slight paranoid reguarding NYPD. He is treated and provided with support as required.

Patient Name SCHOOLCRAFT, ADRIAN Medical Record No. 1298984

Account Number 130381874 Date 11/1/2009

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

11/3/2009	12:55	MC6	Pt. remains on unit resting on streatcher this time. He is quite interactive and even mannered.He refused AM medications and ADLS and appearance are good. Verbal : rate normal, volume normal, cognitive. He still displays concern about NYPD actions towards him and paranoid at times. Menory inatact. He is treated and provided with care and support as required. Pts report give to psyh III pending 2 P.C.
11/3/2009	14:06	MC6	Pt. 2 P.C. Completed and pt and documents provided to patient. Report endorsed to Psych III. He departed unit in wheelchair with cothing and escorted by security.

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved

Primary RN (Print) Calise, Michael (RN)

Jamaica Hospital Medical Center Triage

Category: 4 ESI-4 (Less Ur

Arrival Date/Time		Triage Time	Waiting Rm Time	Exam Rm Time
11/1/2009	8:57	13:44	10:34	13:44

PCP Staff Status: | Family Physician: NA | Transported by: Police | Mode: Walked

Historian: Police

Police Dept: Custody No | Notification Yes | Beat #

Chief Complaint: PSYCH EVAL

Onset Time: 2 Day(s) **Location:**

Associated Sxs / Pertinent History

Past Medical Histor Additional:

- [x] No Significant PMHx
- [ ] Asthma [ ] COPD [ ] CAD [ ] Cancer [ ] CHF [ ] CVA
- [ ] DM [ ] HTN [ ] Psych [ ] Renal [ ] Seizures [ ] Substance Abuse

Medications

- [x] No Meds [ ] Unknown

Allergies

No Known Drug Allergies

Immunizations UTD? Unknown

TB Hx, PPD Pos or Infectious Exposures? No

**If yes to TB or Infectious question take precautions*

Mental Status / Psychological Eval

Alert Oriented

Glascow Coma Scale

Eye	Spontaneous
Verbal	Oriented
Motor	Obeys
Total	15

OB/Gyn

G	P	Ab	Miscarriages
0	0	0	0

Lung Sounds

	R	L
Clear	☑	☑
Diminished	☐	☐
Wheezes	☐	☐
Rales	☐	☐
Rhonchi	☐	☐
Retractions	☐	☐

Eyes

	R	L
Equal	☑	☑
Reactive	☐	☐
Fixed	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Cataract	☐	☐

Skin

Color	Normal
Temp	Normal
Moist	Normal

Extremities

Pulses: Pulses Intact

ROM: Full ROM

Nutrition

Normal

Fall Risk Assessment

No Fall Risks Identified

Suicide Risk Assessment

No risk identified

Plan

MHU WR Time 10:34

Triage Nurse: Woodruff, Brian (RN)

Triage II: BWO

Triage III: BWO

Domestic Violence Assessment

Are you being hurt by someone you live with or who takes care of you?

Yes/No NA

* Mandatory completion of Domestic Violence Referral.

Functional D/C Planning

Daily Living	Independent
Living Conditions	Alone
Going Home with	Unknown

Assessing Patient's, Child's or Parent's readiness to learn

Primary Language	English
Assessed Disability	No Disability
Communication Barrier	☐
Language Translator	☐
Motivation Level	Low
Knowledge Level	Low
Comprehension Ability	Med

Patient Name
SCHOOLCRAFT,ADRIAN

Medical Record Number
1298984

Account Number
130381874

DOB	06/21/1975
Age	34 Years
Gender	Male

Vitals

Tem

Oral	99.0
Rectal	
Tympanic	

Pulse

Right	115
Left	

Respirations 18

Blood Pressure

Right	139/80
Left	

Pulse Ox xx

Weight (Kg 109 Kg

Height 6'3" **Head Circumferenc**

Pain Scale No Pain

- [ ] LWBS
- [ ] LW Completed Tx/ Eloped
- [ ] AMA
- [ ] AMA Refused
- [x] Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381874** **11/1/2009**

Emergency Department Pharmacy and Supply Charges

Diagnostics	
Diagnostic Ordered	**Charge Code**
CBC	0
Pulse Ox	0

Nurse LOS **Charge Code**

Jamaica Hospital Medical Center

Medication Reconciliation

Patient Name	SCHOOLCRAFT, ADRIAN	Medical Record No.	1298984
Account Number	130381874	Date of ED Visit	11/1/2009

Allergies

No Known Drug Allergies

Home Medications

Medications Administered in the Emergency Department

Medication Prescription provided on Discharge

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 99
ADM: 11/01/2009 08:54 162B 130381874
ALDANA-BERNIER, LILIAN R PSYC

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of information:

I hereby authorize and direct Jamaica Hospital having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

11/2/09 — Refused
Date — Signature of Patient or Authorized Representative

Assignment to Jamaica Hospital

I hereby assign, transfer, and set over to Jamaica Hospital sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

11/2/09 — Refused
Date — Signature of Insured or Authorized Representative

Safe Medical Device Act

I consent to the provision of my social security number to the manufacturer of any device that must betracked pursuant to the mandates of the Safe Medical Device Act. I understand that the manufacturer will be given my social security number only for the purpose of finding me in the event that a medical device, which is implanted in my body, or used in my home is defective.

Date — Refused
Signature of Insured or Authorized Representative

Patient Entitled to Medicare Benefits

I certify that the information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

Date — Signature of Insured or Authorized Representative

Financial Agreement

For and in consideration of services rendered or to be rendered by the *Jamaica Hospital*, to the patient whose name appears below, the undersigned (jointly and severally, if more than once) hereby agree(s) to be fully and totally responsible to the hospital for payment of all charges as submitted by the Hospital on the account of said patient and make payment in accordance with the policy of payment of bills at said Hospital. It is further agreed that the charges as incurred represent the fair and reasonable value of services rendered and are in accordance with the posted charges of the Hospital which are available upon request. Payment may be demanded at any time, and failure to demand payment of the patient shall not be a prerequisite to my (our) immediate responsibility for payment.

The undersigned has read the above, been informed of its nature and significance and acknowledges the contents of same and has received a copy of this agreement.

Dated _____ — Guarantor

SCHOOLCRAFT, ADRIAN
Name of Patient — Address - Guarantor

11/01/2009 08:54
Hospital No. — Date of Admission — Telephone - Guarantor

Date of Discharge — Witness — Date

FORM NO. J00123

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 11/01/2009 162B 99 130381874
ALDANA-BERNIER, LILIAN R PSYC

CONSENTS

PERMISSION FOR TREATMENT

I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THE PATIENT WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE 11-02-09

GUARANTEE OF PAYMENT

FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT.
I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TREATMENT

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

AUTHORIZE OF PAYMENT

I HEREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

FORM NO. J00018-2C

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 11/01/2009 162B
ALDANA-BERNIER, LILIAN R PSYC99 130381874

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative

Relationship to patient

Date

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice Privacy Practices at this time.

Signature of patient or authorized representative

Relationship to patient

Date

THIS FORM IS PART OF THE MEDICAL RECORD

M00011 9/06

JAMAICA HOSPITAL MEDICAL CENTER

Jamaica Hospital Medical Center
8900 Van Wyck Expressway, Jamaica, New York 11418
Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, heath maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name this 2 day of Nov, 2007.

P + RTS

YOU SIGN HERE: _____

PRINTED NAME: SCHOOLCRAFT ADRIAN

ADDRESS: 82 60 88 PL RIDGEWOOD NY 11385

MEDICAL RECORD # 1298984

WITNESS: _____

PRINT NAME/TITLE: _____

ADDRESS: 8900 Van Wyck Expressway, Jamaica, New York 11418

Form No. J00023

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 99
ADM: 11/01/2009 08:54 162B 130381874
ALDANA-BERNIER, LILIAN R PSYC

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

RA RAS

This release is valid for one year from 11-2-09 (today's date).

11-2-09
Signature of Patient (or legal representative) (Date)

Description of legal representative's authority to act on behalf of the patient.

Patient's Health Plan ID#: _____

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.

Form No. J00027

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 99
ADM: 11/01/2009 08:54 1628 130381874
ALDANA-BERNIER, LILIAN R PSYC

Please provide the following information and sign the patient certification so we may accurately bill Medicare.

ALL PATIENTS

1. How old are you?_____ Birth Date ___ / ___ / ___

2. Are you eligible for any programs (including government programs) which could pay for this service? e.g.: Black Lung Medical Benefits or Veteran's Administration
☐ Yes ☐ No

If Yes, Name of Program:_____

3. Is this service for treatment of work related injury/accident?
☐ Yes ☐ No If yes, date of Injury Accident ___ / ___ / ___

Employer Name and Address:_____

_____

Name and Address of Worker's Compensation plan

_____

File/Case # (if available)_____

Medicare #:_____

4. Is this service for the treatment of an illness/accident for which another party could be held responsible? ☐ Yes ☐ No
If yes, please provide the following information:

Name and Address of no fault/liability insurer:_____

_____

Policy #:_____ Date of Accident: ___ / ___ / ___

Type of Accident:_____

Name of Insured:_____

5. Are you currently enrolled in a hospice ☐ Yes ☐ No

If yes, Name and Address of facility_____

_____

Do you have a revocation letter? ☐ Yes ☐ No

PATIENTS UNDER AGE 65

1. Are you currently employed (including self-employment)?
☐ Yes ☐ No If no, Disability Date ___ / ___ / ___
If yes, does your employer have: *(please include Part and Full time employees)*
☐ Less than 20 employees ☐ 20-99 employees
☐ 100 employees or more

PATIENTS OVER AGE 65

1. Are you currently employed (including self-employment)?
☐ Yes ☐ No If no, Retirement Date ___ / ___ / ___
If yes, does your employer have: *(please include Part and Full time employees)*
☐ Less than 20 employees ☐ 20-99 employees
☐ 100 employees or more

All PATIENTS

1. Are you married? ☐ Yes ☐ No ☐ Widower or Widow. If yes, is your spouse working? ☐ Yes ☐ No If yes, does your spouse's employer have: *(please include Part and Full time employees)*
☐ Less than 20 employees ☐ 20-99 employees ☐ 100 employees or more Spouse's Retirement Date: ___ /___ /___

3. Do you have insurance coverage through employee group health plan based on your current employment or a family member's current employment? ☐ Yes ☐ No If yes, Name of Policy Holder:_____
Relationship to patient, (Self, Spouse)_____
Name and Address of Employer:_____
Name and Address of Insurance Company:_____
Group/Policy Number:_____

4. Are you a member of an HMO? *(Please note if HMO authorization guidelines are not followed. Medicare will not pay, the beneficiary will be responsible for payment).* ☐ Yes ☐ No
If Yes, is this coverage through an Employer Group Health Plan? ☐ Yes ☐ No

5. Have you received a kidney transplant or dialysis treatments? ☐ Yes ☐ No If Yes, Date of Transplant ___ / ___ / ___
Date maintenance dialysis begins ___ / ___ / ___ Have you received self-dialysis training? ☐ Yes ☐ No

Patient or Guarantor Certification

I have answered the above questions completely and accurately to the best of my knowledge. I understand that inaccurate information can affect the amount of payment ultimately made by Medicare and other insurance carriers for covered services.

Patient/Guarantor Signature:_____ Date:_____

Hospital Representative/Witness:_____ Date:_____

FORM NO. M00003

Empire BlueCross BlueShield

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 99
ADM: 11/01/2009 08:54 162B 130381874
ALDANA-BERNIER, LILIAN R PSYC

COORDINATION OF BENEFITS QUESTIONNAIRE

Instructions: Please fill out **all applicable** sections completely by filling in the applicable circle(s) within each section and print **clearly in black or blue ink** in order for us to quickly and accurately process your request.

Section 1 - Member Insurance Information

Are any family members that are covered under the policy above covered under any other group health insurance policy (currently or during the past 2 years)?

◯ Yes ◯ Medicare Only ◯ ESRD ◯ Medicaid ◯ CHAMPUS / TRICARE ◯ No

Complete sections 2 - 7 | *Complete sections 3 - 5 and 7* | *Skip to section 7* | *Skip to section 7*

Section 2 - Other Insurance Information

Indicate name of other insurance carrier (fill in **only** one)
(NOTE: If more than one other coverage, please provide the other carrier information from this section on additional page).

◯ Aetna / Us Health Care ◯ Blue Shield of NENY ◯ CDPHP ◯ CIGNA ◯ GHI
◯ HIP ◯ Horizon BC of NJ ◯ MVP ◯ Oxford ◯ United Health Care
◯ Other (Name of Carrier)

Customer Service Telephone Number: ___ — ___ — ____

Type of enrollment (fill in only one): ◯ Individual ◯ Family ◯ Employee & Spouse ◯ Parent & Child(ren)

Type of coverage (fill in all that apply): ◯ Hospital ◯ Medical ◯ Prescription Drug ◯ Dental ◯ Vision ◯ Mental Health / Substance Abuse

Effective date of the other coverage: Effective Date (mmddyyyy) Termination Date (mmddyyyy) *(if applicable)*

Section 3 - Primary Contact Holder Information of Other Insurance

Primary Contract Holder on the Policy indicated in Section 2: Last Name First Name

Identification Number or Medicare ID number: *(include all letters and prefix)*

Group Number: *(if available):*

Relationship of this contract holder to the contract holder listed at the top of this form:

◯ Self ◯ Spouse ◯ Dependent ◯ Ex-Spouse or Legally Separated Spouse

If relationship is "SELF" or "SPOUSE", indicate employment status

◯ Actively working with employer offering other coverage.
◯ Not actively working / Long Term Disability
◯ Retired from employer providing other coverage. *If retired, date of retirement:*

Services provided by Empire Health Choice HMO, Inc. and/or Empire Health Choice Assurance, Inc., licensees of Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shields plans.

Form No. M00017J

HOOLCRAFT , ADRIAN

JAMAICA HOSPITAL MEDICAL CENTER

FACE SHEET

ACCOUNT NUMBER	MEDICAL RECORD NUMBER	ADMIT DATE & TIME	BAR CODE-MEDICAL RECORD NUMBER
130381874	1298984	11/01/2009 08:54	

LOCATION	FIN CLASS	SOURCE	TYPE	DISCHARGE DATE & TIME	BAR CODE-ACCOUNT NUMBER
162B	19	1	E		

PATIENT

LAST NAME	FIRST NAME	MI	AKA	VETERAN
SCHOOLCRAFT	ADRIAN			N

DATE OF BIRTH	AGE	SEX	REL	MAR ST	RACE	PLACE OF BIRTH	LANGUAGE	INTERPRETER NEEDED
06/21/1975	34Y	M	NO	S	W	NY	ENG	N

ADDRESS	CITY	STATE	ZIP
82 60 88 PL	RIDGEWOOD	NY	11385

TELEPHONE NUMBER	OCCUPATION	SOCIAL SECURITY NUMBER
(718)570-6224		***-**-****

EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
UNKNOWN					(999)999-9999

NEXT OF KIN	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
SCHOOLCRAFT, SELF	09	82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMERGENCY CONTACT NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER
SCHOOLCRAFT,	01		(718)570-6224

MEDICAL

ATTENDING PHYSICIAN / CODE	PVT./SERV	OTHER PHYSICIAN / CODE	MEDICAL SERVICE
ALDANA-BERNIER, LILIAN R PSYC 3099			PSY

ADMITTING DIAGNOSIS	ICD-9-CM CODE
GEN PSYCHIATRIC EXAM NEC	V70.2

ADMITTING PHYSICIAN / CODE	NEWBORN WEIGHT	RESERVATION DATE & TIME	TEAM COLOR
		// :	

GUARANTOR

GUARANTOR NAME	RELATIONSHIP	OCCUPATION	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01		999-99-9999

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMPLOYER	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
UNKNOWN					(999)999-9999

INSURANCE

PLAN CODE / PRIMARY INSURANCE	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER
AETN AETNA US HEALTHCARE	BBM6PBBA	US0080410090	PENDING

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
PO BOX 981109	EL PASO	TX	799981109	(800)451-8843

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01	06/21/1975	***-**-****

SECONDARY CARRIER	POLICY NUMBER	SEQ / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER

TERTIARY CARRIER	POLICY NUMBER	SEQ / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DATE OF PREVIOUS HOSPITAL ADMISSION	FACILITY NAME	ADMITTED BY
	UNSPECIFIED	calmonte

FORM NO M00001

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

LOCATION: 162B

DATE AND TIME OF ARRIVAL 11/01/2009 08:54

EMERGENCY MEDICINE RECORD

REGISTRATION | MEDICAL RECORD NO. 1298984 calmonte | PATIENT TYPE E | PATIENT ACCOUNT NO 130381874

PATIENT'S NAME		SOCIAL SECURITY NO	DATE OF BIRTH	AGE
SCHOOLCRAFT	ADRIAN 469 97 6997	***-**-****	06/21/1975	34Y

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	PLACE OF BIRTH
82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224	NY

FIN. CL.	SEX	RACE	RELIGION	MARITAL STATUS	FATHER'S NAME	MOTHER'S MAIDEN NAME, FIRST NAME
99	M	W	NO	S		

PRIVATE M.D. NAME OR CLINIC NAME	PATIENT COMPLAINT	LANGUAGE	INTERP. REQ
NA	PSYCH EVAL	ENG	N

MODE OF ARRIVAL	ACCOMPANIED BY	RELATIONSHIP	TELEPHONE NO.	INJURED AT WORK?	AUTO ACCIDENT?
2					

DATE AND TIME OF ACCIDENT | POLICE OFFICER NAME & BADGE NO. | PCT. NO. | REFERRED FROM: ☐ PMD ☐ TRUMP ☐ CLINIC ☐ FP ☐ OTHER

NEXT OF KIN	TELEPHONE NO.	NEXT OF KIN ADDRESS			RELATIONSHIP TO PATIENT
SCHOOLCRAFT, SELF	(718)570-6224	82 60 88 PL	RIDGEWOOD	NY 11385	09

FINANCIAL - INSURANCE

GUARANTOR'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
SCHOOLCRAFT, ADRIAN	82 60 88 PL	RIDGEWOOD	NY	11385

GUARANTOR'S SOC. SEC. NO.	TELEPHONE NO.	GUARANTOR'S EMPLOYER	ADDRESS	TELEPHONE NO.
999-99-9999	(718)570-6224	UNEMPLOYED		(999)999-9999

PATIENT'S EMPLOYER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
UNEMPLOYED				

INSURANCE #1: NAME NO COVERAGE/CHARITY CARE | GROUP NO. | POLICY NO. ~~469978997~~ BCM GPBPA

INSURANCE #2: NAME | GROUP NO. | POLICY NO. eff 11/14/05

HOSPITALIZED PAST 60 DAYS	IF YES, WHERE AND WHEN?	PLACE OF ACCIDENT	CRIME VICTIM PCT. NO.	CRIME VICTIM COMPLAINT NO.

COMMENTS: (800) 624-0756

NURSING

VITAL SIGNS

TIME	B.P.	PULSE	RESP	TEMP
TIME	B.P.	PULSE	RESP	TEMP

#1008589

IF ORDERED, CHECK WHEN COMPLETED:

☐ EKG ☐ CARDIAC MONITOR ☐ IV ANGIO# FLUID DDL ☐ OXYGEN GIVEN

INITIALS INITIALS INITIALS METHOD INITIALS

NURSES NOTES ☐ ADVANCED DIRECTIVES DISCUSSED HEALTH CARE PROXY ☐YES ☐NO AGENT'S NAME:

RN SIGNATURE

DATE	TIME	NON-MEDICATION ORDERS (EKG, LABS, CULTURES, ETC.)	MD SIGNATURE	RN SIGNATURE	TIME

MEDICATION ORDERS

DATE	TIME	MEDICATION	DOSE	ROUTE	MD SIGNATURE	RN SIGNATURE	TIME

ACCOUNTING DEPT COPY

FORM NO. J00018

THE JAMAICA HOSPITAL MEDICAL CENTER

MENTAL HEALTH CLEARANCE FORM

TODAY'S DATE: 10-02-09

TO: _____

FROM: _____

REASON FOR REFERRAL:

Eligibility _____

Authorization _____

Admission Date _____

School craft, ARIAN | 130381874 | PER
Patient's Name | Hospital # | Room #

469-97-6997
6-21-1975

Notification of Impending Referral Received Via:

Mail___ Fax___ Brought In___ Phoned In_____

INSURANCE INFORMATION

NAME OF INSURED: Schoolcraft, ARIAN

INSURANCE COMPANY NAME: AETNA

CONTACT PERSON: _____

INSURANCE CO. TELEPHONE NO: (800) 451-8843

INSURANCE COMPANY ADDRESS: _____

EXPLANATION OF MENTAL HEALTH BENEFITS(# of days authorized, etc.):

*Prior auth needed Before admitting to psych unit.
Active Cov AETNA ID# 111631788 EFF 11-01-2007

AUTHORIZATION NO.: pending PRE CERT. COORDINATOR NAME: _____

DISPOSITION OF INSURANCE INQUIRY:

APPROVED ☑ DENIED ☐ PENDING PHYSICIAN CONTACT ☐

PHYSICIAN NOTES: fv

PHYSICIAN NAME: MD

* Financial Investigation (White Copy) * Mental Health Clinician (Pink Copy) * Social Work (Yellow Copy)

3/12/96 (MHAUTHZ.WK3) FIN. INV.INS. UNIT

THE JAMAICA HOSPITAL MEDICAL CENTER

MENTAL HEALTH CLEARANCE FORM

TODAY'S DATE: 11/3/05

TO: _____

FROM: _____

Patient's Name: Shoolcraft, Adrian

Hospital #: 15038174

Room #: PEP

Admission Date: _____

REASON FOR REFERRAL:

Eligibility _____

Authorization _____

Notification of Impending Referral Received Via:

Mail ___ Fax ___ Brought In ___ Phoned In _____

INSURANCE INFORMATION

NAME OF INSURED: _____

INSURANCE COMPANY NAME: Aetna

CONTACT PERSON: _____

INSURANCE CO. TELEPHONE NO: 609 624-0756

INSURANCE COMPANY ADDRESS: _____

EXPLANATION OF MENTAL HEALTH BENEFITS(# of days authorized, etc.): Aetna Aetna # BBMGPBPA Eff 11/14/05 - Deductible met

AUTHORIZATION NO.: Pending PRE CERT. COORDINATOR NAME: _____

DISPOSITION OF INSURANCE INQUIRY:

APPROVED ☑ DENIED ☐ PENDING PHYSICIAN CONTACT ☐

PHYSICIAN NOTES: Yr

PHYSICIAN NAME: _____

* Financial Investigation (White Copy) * Mental Health Clinician (Pink Copy) * Social Work (Yellow Copy)

3/12/96 (MHAUTHZ. WK3) FIN. INV.INS. UNIT

Emdeon, Inc.

Batch: Assistant Page 1 - 5

11/03/09 13:49:35 T000188-CARIAS
Status: CLOSED Id:176.1 Record: 1

Aetna
Subscriber Eligibility v2.2

------Input / Response Information------
Provider ID 111631788
Subscriber ID
(On File) BBM6PBPA
Date Of Service 11/03/2009
SSN 469976997
Date Of Birth 06/21/1975
Last Name SCHOOLCRAFT
First Name ADRIAN
Svc/Proc Code 30
----------Aetna Information----------
Trans Ref # 091249298WEB
Requester ID 111631788
Plan Ntwk ID GN01
Group/Policy US0080410090011
Group/Policy PACES - CITY OF N Y
Plan ID 5691654
Sub Last Name SCHOOLCRAFT
Sub First Name ADRIAN
Sub Middle Name P
Sub Birth Date 06/21/1975
Sub Gender MALE
Address 55 92ND ST APT B2
BROOKLYN
NY
11209
Eligibility
11/01/2007
Service
11/03/2009 - 11/03/2009
Trace 1 1151820050231103091249298
9MEDIFAXXX
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
000000149
Facility
Identification Code Facility Identifier
Other Source of Data
----------Benefit----------
Eligibility
11/14/2005
Active Coverage
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
Insurance Type Code HM
Health Maintenance Organization (HMO)
HMO
Usage Commercial
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level IND
Individual
Service Type Code 30
Health Benefit Plan Coverage
Period Lifetime
In-Network Yes
Message UNLIMITED LIFETIME BENEFITS
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
Message NO NON-EMERGENCY COVG OON
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
Message Plan req referral and precert
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Cost Containment
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
In-Network Yes
Message NO PENALTY FAILURE TO PRECERT
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Active Coverage
Covg Level FAM
Family
Service Type Code 33
Chiropractic
HMO
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Insurance
Covg Level IND
Individual
Service Type Code 33
Chiropractic

Percent 100
In-Network Yes
Message Chiro
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 33
Chiropractic
Amount $20.00
In-Network Yes
Message Chiro
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 33
Chiropractic
Period Day
Amount $20.00
In-Network Yes
Message Specialist Chiro Office Visits
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 33
Chiropractic
Message 1 COPAY/SVC based on PROV type
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Active Coverage
Covg Level FAM
Family
Service Type Code 48
Hospital - Inpatient
HMO
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Co-Insurance
Covg Level IND
Individual
Service Type Code 48
Hospital - Inpatient
Percent 100
In-Network Yes
Message Facility Inpatient Hospital
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 48
Hospital - Inpatient
Amount $300.00
In-Network Yes
Message Facility Inpatient Hospital
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 48
Hospital - Inpatient
Period Admisson
Amount $300.00
In-Network Yes
Message FACILITY IP HOSP-MEDICAL
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 48
Hospital - Inpatient
Message 1 COPAY/SVC based on PROV type
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 48
Hospital - Inpatient
Message Limitations
---Benefit---
Eligibility -
Service 11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 48
Hospital - Inpatient
---Benefit---
Eligibility -
Service

Emdeon, Inc.

Batch: Assistant Page 3 - 5

11/03/2009 - 11/03/2009
Active Coverage
Covg Level FAM
Family
Service Type Code 50
Hospital - Outpatient
HMO
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Insurance
Covg Level IND
Individual
Service Type Code 50
Hospital - Outpatient
Percent 100
In-Network Yes
Message Hospital - O/P Surgery
Message HOSPITAL OUTPATIENT
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 50
Hospital - Outpatient
Amount $75.00
In-Network Yes
Message Hospital - O/P Surgery
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 50
Hospital - Outpatient
Amount $20.00
In-Network Yes
Message HOSPITAL OUTPATIENT
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 50
Hospital - Outpatient
Message 1 COPAY/SVC based on PROV type
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 50
Hospital - Outpatient
Message 1 COINS/SVC based on PROV type
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Active Coverage
Covg Level FAM
Family
Service Type Code 86
Emergency Services
HMO
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Insurance
Covg Level IND
Individual
Service Type Code 86
Emergency Services
Percent 100
In-Network Yes
Message Emergency Room Copay
Message Urgent Care Copay
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 86
Emergency Services
Period Admisson
Amount $75.00
In-Network Yes
Message Emergency Room
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 86
Emergency Services
Amount $75.00
In-Network Yes
Message Emergency Room Copay
---Benefit---
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND

Individual
Service Type Code 86
Emergency Services
Amount $35.00
Network Yes
Message Urgent Care Copay
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 86
Emergency Services
Message 1 COPAY/SVC based on PROV type
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 86
Emergency Services
Message 1 COINS/SVC based on PROV type
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 86
Emergency Services
Message Limitations
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 86
Emergency Services
Message call 1/800-624-0756
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Active Coverage
Covg Level FAM
Family
Service Type Code 98
Professional (Physician) Visit -
Office
HMO
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Insurance
Covg Level IND
Individual
Service Type Code 98
Professional (Physician) Visit -
Office
Service Percent 100
In-Network Yes
Message PCP After Hours
Message PCP During Hours
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 98
Professional (Physician) Visit -
Office
Amount $20.00
In-Network Yes
Message PCP After Hours
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 98
Professional (Physician) Visit -
Office
Amount $15.00
In-Network Yes
Message PCP During Hours
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Co-Payment
Covg Level IND
Individual
Service Type Code 98
Professional (Physician) Visit -
Office
Period Day
Amount $20.00
In-Network Yes
Message Specialist Off Visit Consult
----------Benefit----------
Eligibility
-
Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family

Emdeon, Inc.

Batch: Assistant

Service Type Code 98
Professional (Physician) Visit - Office
Message 1 COPAY/SVC based on PROV type
----------Benefit----------
Eligibility - Service
11/03/2009 - 11/03/2009
Limitations
Covg Level FAM
Family
Service Type Code 98
Professional (Physician) Visit - Office
Message 1 COINS/SVC based on PROV type
----------PCP----------
Period Start
07/09/2008
Name HERTZEL SURE
Phone 718-760-0797
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
Insurance Type Code HM
Health Maintenance Organization (HMO)
----------Gateway Provider----------
Eligibility - Service
11/03/2009 - 11/03/2009
Identification Code 1083727762
Name SURE, HERTZEL , MD
9425 60TH AVE UNIT B4
ELMHURST
NY
11373
Covg Level FAM
Family
Service Type Code 30
Health Benefit Plan Coverage
Insurance Type Code HM
Health Maintenance Organization (HMO)
----------Disclaimer----------
Receipt of this information does not guaranty payment under state law. Should Provider wish to obtain verification that payment will be made, or if member information returned differs from Provider's patient records, call Aetna Member Services.

========== Transaction Stats ==========
Query: - PASS

CARTAS EMDEON ASSISTANT Page 1 of 3
11/03/09 13:49:35 Status: CLOSED
ID: T000188

Aetna - Subscriber Eligibility v2.2

SEARCH INFORMATION:	INPUT	ON FILE
Provider ID:	111631788	
Subscriber ID:		BBM6PBPA
Date Of Service:	11/03/2009	
SSN:	469976997	
Date Of Birth:	06/21/1975	
Last Name:	SCHOOLCRAFT	
First Name:	ADRIAN	
Svc/Proc Code:	30	

AETNA INFORMATION

Plan Ntwk ID:	GN01
Group/Policy:	US0080410090011
Group/Policy:	PACES - CITY OF N Y
Plan ID:	5691654
Sub Name:	SCHOOLCRAFT, ADRIAN P
Sub Birth Date:	06/21/1975
Sub Gender:	MALE
Address:	55 92ND ST APT E2 BROOKLYN, NY 11209
Dates:	Eligibility - 11/01/2007 Service - 11/03/2009 - 11/03/2009

CHIROPRACTIC

Network	Coverage	Type	Value	Period	Additional Info
In	Individual	Co-Insurance	100		Message: Chiro
		Co-Payment	$20.00		Message: Chiro
		Co-Payment	$20.00	Day	Message: Specialist Chiro Office Visits
	Family	Active Coverage			HMO
		Limitations			Message: 1 COPAY/SVC based on PROV type

EMERGENCY SERVICES

Network	Coverage	Type	Value	Period	Additional Info
In	Individual	Co-Insurance	100		Message: Emergency Room Copay
					Message: Urgent Care Copay
		Co-Payment	$75.00	Admisson	Message: Emergency Room
		Co-Payment	$75.00		Message: Emergency Room Copay
		Co-Payment	$35.00		Message: Urgent Care Copay
	Family	Active Coverage			HMO
		Limitations			Message: 1 COPAY/SVC based on PROV type
		Limitations			Message: 1 COINS/SVC based on PROV type
		Limitations			Message: Limitations
		Limitations			Message: call 1/800-624-0756

HEALTH BENEFIT PLAN COVERAGE

Network	Coverage	Type	Value	Period	Additional Info
In	Family	Cost Containment			Message: NO PENALTY FAILURE TO PRECERT
In	Individual	Limitations		Lifetime	Message: UNLIMITED LIFETIME BENEFITS
	Family	Active Coverage			Insurance Type Code: HM Health Maintenance Organization (HMO) HMO
		Limitations			Message: Commercial Message: NO NON-EMERGENCY COVG OON

		Limitations			Message: Plan req referral and precert

HOSPITAL - INPATIENT

Network	Coverage	Type	Value	Period	Additional Info
In	Individual	Co-Insurance	100		Message: Facility Inpatient Hospital
		Co-Payment	$300.00		Message: Facility Inpatient Hospital
		Co-Payment	$300.00	Admisson	Message: FACILITY IP HOSP-MEDICAL
	Family	Active Coverage			HMO
		Limitations			Message: 1 COPAY/SVC based on PROV type
		Limitations			Message: Limitations
		Limitations			

HOSPITAL - OUTPATIENT

Network	Coverage	Type	Value	Period	Additional Info
In	Individual	Co-Insurance	100		Message: Hospital - O/P Surgery
					Message: HOSPITAL OUTPATIENT
		Co-Payment	$75.00		Message: Hospital - O/P Surgery
		Co-Payment	$20.00		Message: HOSPITAL OUTPATIENT
	Family	Active Coverage			HMO
		Limitations			Message: 1 COPAY/SVC based on PROV type
		Limitations			Message: 1 COINS/SVC based on PROV type

PROFESSIONAL (PHYSICIAN) VISIT - OFFICE

Network	Coverage	Type	Value	Period	Additional Info
In	Individual	Co-Insurance	100		Message: PCP After Hours
					Message: PCP During Hours
		Co-Payment	$20.00		Message: PCP After Hours
		Co-Payment	$15.00		Message: PCP During Hours
		Co-Payment	$20.00	Day	Message: Specialist Off Visit Consult
	Family	Active Coverage			HMO
		Limitations			Message: 1 COPAY/SVC based on PROV type
		Limitations			Message: 1 COINS/SVC based on PROV type

BENEFIT

Eligibility
-
Service
11/03/2009 - 11/03/2009
000000149
Facility
Identification Code: Facility Identifier
Other Source of Data

PCP

Period Start - 07/09/2008
Name: HERTZEL SURE
Phone: 718-760-0797
Covg Level: FAM - Family
Service Type: 30 - Health Benefit Plan Coverage
Insurance Type: HM - Health Maintenance Organization (HMO)

GATEWAY PROVIDER

Eligibility
-

Service
11/03/2009 - 11/03/2009

Identification Code: 1083727762
Name: SURE, HERTZEL , MD
9425 60TH AVE UNIT B4
ELMHURST, NY 11373
Covg Level: FAM - Family
Service Type: 30 - Health Benefit Plan Coverage
Insurance Type: HM - Health Maintenance Organization (HMO)

DISCLAIMER
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TRANSACTION STATS
Query: - PASS

eMedNY ePACES

JAMAICA HOSPITAL MED CTR - 1225176175

Change Provider: JAMAICA HOSPITAL MED CTR - 1225176175

Claims
- Eligibility Response Details
- Status Inquiry
- Status Responses

MEVS
- Eligibility Request
- Eligibility Responses
- SA Request
- SA Responses
- SA Confirmation
- SA Confirm Responses
- DVS Request
- DVS Responses
- DVS Confirmation
- DVS Confirm Responses

Prior Approval
- PA Request
- PA Response

Support Files
- Other Files

Eligibility Response Details

Eligibility Information:

Subscriber/Insured Not Found

Client Information:

Client ID:		Date of Birth:	6/21/1945
Client Name:	SCHOOLCRAFT ADRIAN	Gender:	M
		County:	
		Office:	

Medicaid Coverage Information:

Coverage Level:		Date of Service:	11/03/2009
Insurance Type:		Anniversary:	
		Recertification:	

Medicaid Managed Care

Plan Name:

Carrier Code:

Medicaid Restricted Recipient

Restriction Type:

DOH

Co-Payment Information

Co-Pay Remaining:

Medicaid Messages

1. Individual Exception Code:
2. Category of Assistance:

Additional Payer Information

Empire BlueCross BlueShield

Home | Members | Employers | Brokers | Physicians | Facilities

Online Services | Working With Empire | Facility Library | Empire's Plans | About E

Logout

Blue Tools℠

- Facility Sourcebook
- Medical Policies
- Help
  - Customer Service
  - Technical Support

For Registered Facilities:
- Member Search
- Search Claims
- Search EOBs
- Create Pre-Certification
- Create & Search Radiology Pre-Certification
- Pre-Certification Search
- Member Center
- My Profile
- Track Claim Status

Support Library

- Member Benefits
  - Medicare Advantage
  - Empire Product Guide
  - COBRA, FEOJ NYS Guide
- Claims
  - 837 INPT Claim
  - Product Prefixes
  - Claim Submit Requirements
  - Appeals Process
  - Claim Submit Requirements
  - Appeals Process
  - Coordination of Benefits
  - Medicare Secondary Payer
  - NYS Claims Submitter Guide
  - NYC Claims Submitter Guide
- Client and Program
  - Program Information
  - Claims Submission
  - Out of Area Members
- Training
  - Medicare Advantage & Part D
- E-Commerce Training
  - EligCard
  - Empire Provider Online
- Helpful Tools
  - Search Specialty
  - Claim Formation
  - Claim Messages
  - Input Claims

Member Search

No match was found. Please check the Member's Identification Card for

For further assistance, please contact the Member Services number listed on the back of the patient's identification card.

Enter your patient's information in the fields below and then click search. If you a attempting to search for a member in our national systems you must include the prefix.

Subscriber Dependent

Member ID: Prefix 469976997 ID *

Patient Name: First Name Last Name

Date of Birth: 06 / 21 / 1975 * (MM) (DD) (YYYY)

Note: To view a sample ID card, click here

* Minimum Required for Search

SEARCH

Empire BlueCross BlueShield

Home | Members | Employers | Brokers | Physicians | Facilities

Online Services | Working With Empire | Facility Library | Empire's Plans | About E

Logout

Blue Tools℠

Facility Sourcebook
Medical Policies
Help
Customer Service
Technical Support

For Registered Facilities:
Member Search
Search Claims
Search EOBs
Create Pre-Certification
Create & Search Radiology
Pre-Certification
Pre-Certification Search
Message Center
My Profile
Track Claim Status

Support Library

Member Benefits
Medicare Advantage
Empire Product Guide
COBRA, FED / NYS Guide
Claims
837I NPI Chart
Product Prefixes
Claim Submit Requirements
Appeals Process
Claim Submit Requirements
Appeals Process
Coordination of Benefits
Medicare Secondary Payer
NYS Claims Submitter Guide
NYC Claims Submitter Guide
BlueCard Program
Program Information
Claims Submission
Out of Area Members
Training
Medicare Advantage & [illegible]
[illegible] Training
[illegible]
[illegible]
Helpful Tools
[illegible]
Claim Correction
Claim Messaging
[illegible] Claims

Member Search

No match was found. Please check the Member's information and try again.

For further assistance, please contact the telephone number listed on the back of patient's identification card.

Enter your patient's Information in the fields below and then click search. If you a attempting to search for a member in our national systems you must include the prefix.

○ Subscriber ◉ Dependent

Member ID: [ ] Prefix 469976997 * ID

Patient Name: [ ] First Name [ ] Last Name

Date of Birth: 06 / 21 / 1975 * (MM) (DD) (YYYY)

Note: To view a sample ID card, click here.

* Minimum Required for Search

SEARCH

Emdeon, Inc.

Batch: Assistant Page 1 - 1

11/02/09 17:48:51 T000188-MMERO1
Status: RETRY Id:1350.1 Record: 1

Medicare
Eligibility v2.3

------Input / Response Information------

Provider ID	1245370717
Medicare HIC #	469976997A
Begin DOS	11/02/2009
End DOS	11/02/2009
Date Of Birth	06/21/1975
Last Name	SCHOOLCRAFT
First Name	ADRIAN
Gender	M
Service Type	42
Service Type 2	47
Service Type 3	15
Service Type 4	14
Service Type 5	AG
Service Type 6	30

======= Transaction Stats ==========
Query: - FAIL >RH0247 - Patient Not Found

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 11/01/2009 162B 99 130381874
ALDANA-BERNIER, LILIAN R PSYC

DATE	HISTORY & PHYSICAL	ACTION IF NOT CURRENT
TIME		DT CURRENT ☐ YES ☐ NO
		DPT CURRENT ☐ YES ☐ NO
		MMR CURRENT ☐ YES ☐ NO

IMPRESSIONS

PHYSICIAN NAME (PRINT) I D #

PHYSICIAN NAME (SIGN)

LAB TESTS	TIME	RESULTS TIME
☐ HGB		
☐ HCT		
☐ WBC		
☐ NA		
☐ K		
☐ CL		
☐ CO_2		
☐ BUN/CR	/	/
☐ GLUC		
☐ AMYLASE		
☐ PT/PTT		
☐ UCG		
☐ CPK		

U/A
RBC___ WBC___ Prot___
BLD___ KET___ GLU___

BLOOD GASES	TIME	TIME
PH		
PO_2		
PCO_2		
HCO_3		
HBO_2		
HGB		
HGCO		

EKG RESULTS

RADIOLOGY
X-RAY # ED READING

☐ CHEST
☐ ABDOMEN
☐ C-SPINE
☐ L-SPINE
☐ PELVIS
☐ TIBI/FIBULA L R
☐ FEMUR L R
☐ WRIST L R
☐ ANKLE L R
☐ HIP L R
☐ CT SCAN
☐

ADDITIONAL MD NOTES

CONSULTANT NAME SERVICE TIME CALLED
1
2
3

FINAL DIAGNOSIS CODE

DISPOSITION

☐ ADMITTED, TIME:____ ROOM #____ SERVICE____ ☐ FAMILY MEMBER NOTIFIED____ NAME, RELATIONSHIP

☐ EXPIRED, TIME:____ ☐ M.E. CALLED, TIME:____ ACCEPTED ☐ YES ☐ NO CASE #____

☐ DISCHARGED, TIME:____ ☐ INSTRUCTIONS GIVEN (TYPE)____ ☐ PVT MD NOTIFIED OF DISPOSITION

☐ OTHER____ (AMA, WALK-OUT, TRANSFER) TIME:____ TIME:____ INITIALS

CONDITION ON DISCHARGE____

DISCHARGING PHYSICIAN NAME (PRINT)____ SIGNATURE____ I D #____ DATE____

EMERGENCY DEPT COPY FORM NO. J00018

1

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

49200/2391 FILE 646-957-2486 (FATHER)

LOCATION: CAP 081X

ENCR INITIAL OPT

DATE AND TIME OF ARRIVAL 10/31/2009 23:03

EMERGENCY MEDICINE RECORD

REGISTRATION MEDICAL RECORD NO. 1298984 PATIENT TYPE E PATIENT ACCOUNT NO. 130381015

PATIENT'S NAME		SOCIAL SECURITY NO.	DATE OF BIRTH	AGE
SCHOOLCRAFT	ADRIAN		06/21/1975	34Y

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.	PLACE OF BIRTH

FIN. CL.	SEX	RACE	RELIGION	MARITAL STATUS	FATHER'S NAME	MOTHER'S MAIDEN NAME, FIRST NAME
01	M					

PRIVATE M.D. NAME OR CLINIC NAME	PATIENT COMPLAINT	LANGUAGE	INTERP. REQ.
		ENG	N

MODE OF ARRIVAL	ACCOMPANIED BY	RELATIONSHIP	TELEPHONE NO.	INJURED AT WORK?	AUTO ACCIDENT?

DATE AND TIME OF ACCIDENT	POLICE OFFICER NAME & BADGE NO.	PCT. NO.	REFERRED FROM:
			☐ PMD ☐ TRUMP ☐ CLINIC ☐ FP ☐ OTHER

NEXT OF KIN	TELEPHONE NO.	NEXT OF KIN ADDRESS	RELATIONSHIP TO PATIENT

FINANCIAL - INSURANCE

GUARANTOR'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

GUARANTOR'S SOC. SEC. NO.	TELEPHONE NO.	GUARANTOR'S EMPLOYER	ADDRESS	TELEPHONE NO.

PATIENT'S EMPLOYER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

INSURANCE #1: NAME GROUP NO. POLICY NO.

INSURANCE #2: NAME GROUP NO. POLICY NO.

HOSPITALIZED PAST 60 DAYS?	IF YES, WHERE AND WHEN?	PLACE OF ACCIDENT	CRIME VICTIM PCT. NO.	CRIME VICTIM COMPLAINT NO.

COMMENTS: 11/1 05:56 4HR MTHER X-fo 65 32

NURSING

VITAL SIGNS

TIME	B.P.	PULSE	RESP	TEMP
TIME	B.P.	PULSE	RESP	TEMP

IF ORDERED, CHECK WHEN COMPLETED:

☐ OXYGEN GIVEN

☐ EKG ____ INITIALS ☐ CARDIAC MONITOR ____ INITIALS ☐ IV ANGIO# ____ INITIALS FLUID ____ INITIALS ____ METHOD ____ INITIALS

NURSES NOTES ☐ ADVANCED DIRECTIVES DISCUSSED HEALTH CARE PROXY ☐ YES ☐ NO AGENT'S NAME:

RN SIGNATURE

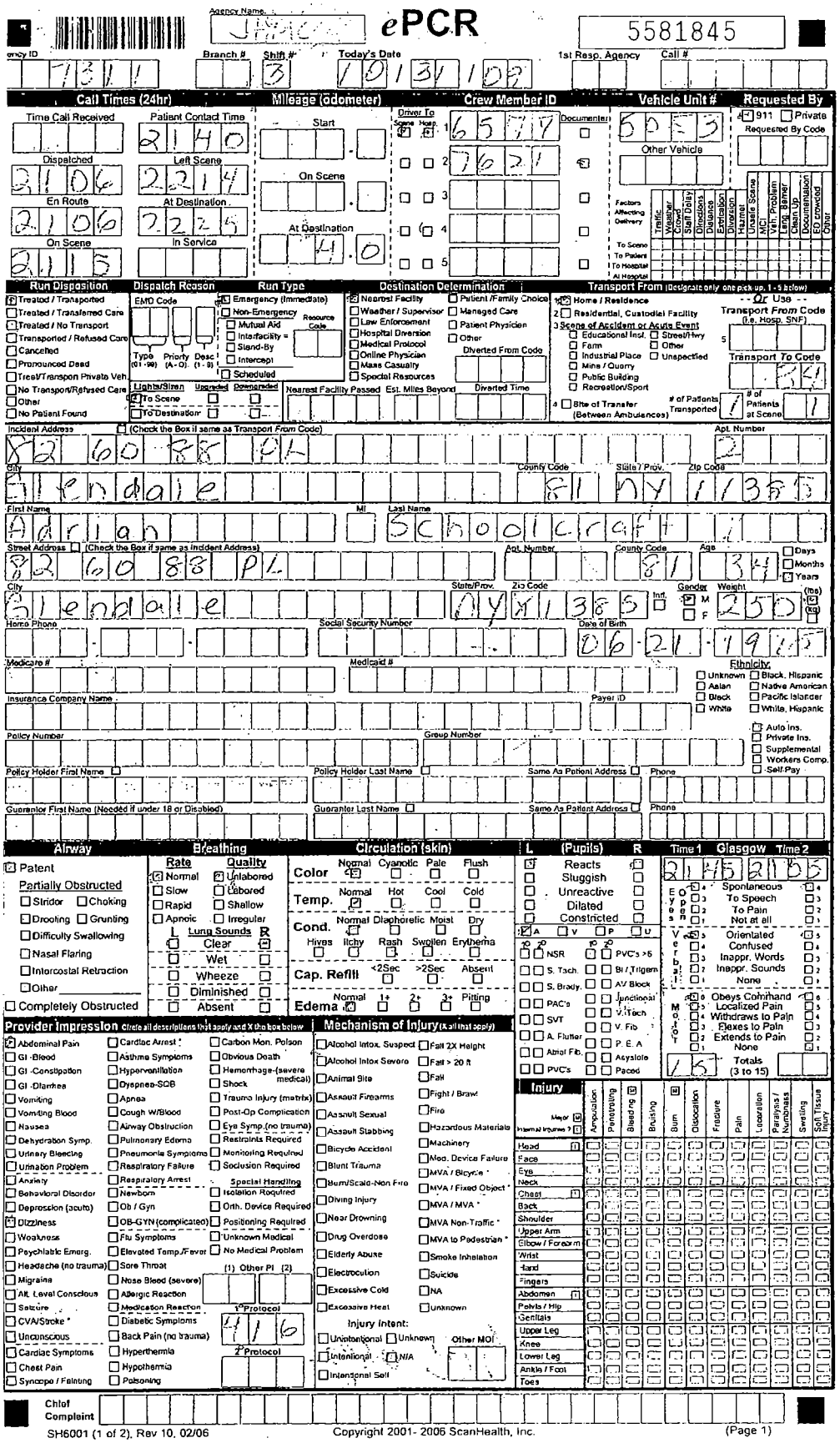
DATE	TIME		NON-MEDICATION ORDERS (EKG, LABS, CULTURES, ETC.)	MD SIGNATURE	RN SIGNATURE	TIME

MEDICATION ORDERS

DATE	TIME	MEDICATION	DOSE	ROUTE	MD SIGNATURE	RN SIGNATURE	TIME

ACCOUNTING DEPT COPY

FORM NO. 100018



ePCR

5581845

Agency Name: JHMC

Agency ID: 7311 | Branch #: | Shift #: 3 | Today's Date: 10/31/02 | 1st Resp. Agency: | Call #:

Call Times (24hr)

Time Call Received	Patient Contact Time	Dispatched	Left Scene	En Route	At Destination	On Scene	In Service
	2140	2106	2214	2106	2225	2115	

Mileage (odometer)

Start: | On Scene: | At Destination: 40

Crew Member ID

Driver To Scene	Hosp.		
☑		1	6577
		2	7621
		3	
		4	
		5	

Documenter:

Vehicle Unit #: 5553

Other Vehicle:

Factors Affecting Delivery: Traffic; Weather; Crowd; Staff Delay; Directions; Distance; Extrication; Hazmat; Multiple; Unsafe Scene; MCI; Veh. Problem; Lang. Barrier; Clean Up; Documentation; EO crowded; Other

To Scene | To Patient | To Hospital | At Hospital

Requested By

☑ 911 ☐ Private

Requested By Code:

Run Disposition

- ☑ Treated / Transported
- ☐ Treated / Transferred Care
- ☐ Treated / No Transport
- ☐ Transported / Refused Care
- ☐ Cancelled
- ☐ Pronounced Dead
- ☐ Treat/Transport Private Veh.
- ☐ No Transport/Refused Care
- ☐ Other
- ☐ No Patient Found

Dispatch Reason

EMD Code: Type (01-99) | Priority (A-O) | Desc (1-9)

Lights/Siren: ☑ To Scene ☐ To Destination — Upgraded ☐ — Downgraded ☐

Run Type

- ☑ Emergency (Immediate)
- ☐ Non-Emergency
- ☐ Mutual Aid
- ☐ Interfacility =
- ☐ Stand-By
- ☐ Intercept
- ☐ Scheduled

Resource Code:

Destination Determination

- ☑ Nearest Facility
- ☐ Weather / Supervisor
- ☐ Law Enforcement
- ☐ Hospital Diversion
- ☐ Medical Protocol
- ☐ Online Physician
- ☐ Mass Casualty
- ☐ Special Resources
- ☐ Patient /Family Choice
- ☐ Managed Care
- ☐ Patient Physician
- ☐ Other

Diverted From Code:

Nearest Facility Passed: | Est. Miles Beyond: | Diverted Time:

Transport From (Designate only one pick up, 1 - 5 below)

1 ☑ Home / Residence
2 ☐ Residential, Custodial Facility
3 Scene of Accident or Acute Event: ☐ Educational Inst. ☐ Street/Hwy ☐ Farm ☐ Other ☐ Industrial Place ☐ Unspecified ☐ Mine / Quarry ☐ Public Building ☐ Recreation/Sport
4 ☐ Site of Transfer (Between Ambulances)
5

-- Or Use --

Transport From Code (i.e. Hosp, SNF):

Transport To Code: SK1

# of Patients Transported: 1 | # of Patients at Scene: 1

Incident Address ☐ (Check the Box if same as Transport From Code): 82 60 8K PL | Apt. Number: 2

City: Glendale | County Code: 81 | State / Prov.: NY | Zip Code: 11385

First Name: Adrian | MI: | **Last Name:** Schoolcraft

Street Address ☐ (Check the Box if same as Incident Address): 82 60 88 PL | Apt. Number: | County Code: 81 | Age: 34 ☐ Days ☐ Months ☑ Years

City: Glendale | State/Prov.: NY | Zip Code: 11385 | Int. ☐ | Gender: ☑ M ☐ F | Weight: 250 (lbs) ☐ (kg)

Home Phone: | Social Security Number: | Date of Birth: 06-21-79

Medicare #: | Medicaid #:

Ethnicity: ☐ Unknown ☐ Black, Hispanic ☐ Asian ☐ Native American ☐ Black ☐ Pacific Islander ☐ White ☐ White, Hispanic

Insurance Company Name: | Payer ID:

☐ Auto Ins. ☐ Private Ins. ☐ Supplemental ☐ Workers Comp. ☐ Self-Pay

Policy Number: | Group Number:

Policy Holder First Name ☐: | Policy Holder Last Name ☐: | Same As Patient Address ☐ | Phone:

Guarantor First Name (Needed if under 18 or Disabled): | Guarantor Last Name ☐: | Same As Patient Address ☐ | Phone:

Airway

☑ Patent

Partially Obstructed
☐ Stridor ☐ Choking ☐ Drooling ☐ Grunting ☐ Difficulty Swallowing ☐ Nasal Flaring ☐ Intercostal Retraction ☐ Other

☐ Completely Obstructed

Breathing

Rate: ☑ Normal ☐ Slow ☐ Rapid ☐ Apneic

Quality: ☑ Unlabored ☐ Labored ☐ Shallow ☐ Irregular

Lung Sounds: L ☑ Clear ☐ Wet ☐ Wheeze ☐ Diminished ☐ Absent — R ☑ Clear ☐ Wet ☐ Wheeze ☐ Diminished ☐ Absent

Circulation (skin)

Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush

Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold

Cond.: ☑ Normal ☐ Diaphoretic ☐ Moist ☐ Dry

☐ Hives ☐ Itchy ☐ Rash ☐ Swollen ☐ Erythema

Cap. Refill: ☐ <2Sec ☐ >2Sec ☐ Absent

Edema: ☑ Normal ☐ 1+ ☐ 2+ ☐ 3+ ☐ Pitting

Pupils

L: ☑ Reacts ☐ Sluggish ☐ Unreactive ☐ Dilated ☐ Constricted

R: ☑ Reacts ☐ Sluggish ☐ Unreactive ☐ Dilated ☐ Constricted

L: ☑ A ☐ V ☐ P ☐ U — R: ☑ A ☐ V ☐ P ☐ U

Glasgow

	Time 1	Time 2
	2145	2155
Eyes	4 Spontaneous	4
	3 To Speech	3
	2 To Pain	2
	1 Not at all	1
Verbal	5 Orientated	5
	4 Confused	4
	3 Inappr. Words	3
	2 Inappr. Sounds	2
	1 None	1
Motor	6 Obeys Command	6
	5 Localized Pain	5
	4 Withdraws to Pain	4
	3 Flexes to Pain	3
	2 Extends to Pain	2
	1 None	1
	15 Totals (3 to 15)	

☐ NSR ☐ S. Tach. ☐ S. Brady. ☐ PAC's ☐ SVT ☐ A. Flutter ☐ Atrial Fib. ☐ PVC's

☐ PVC's >6 ☐ Bi / Trigem ☐ AV Block ☐ Junctional ☐ V. Tach ☐ V. Fib ☐ P. E. A ☐ Asystole ☐ Paced

Provider Impression (Circle all descriptions that apply and X the box below)

☑ Abdominal Pain	☐ Cardiac Arrest *	☐ Carbon Mon. Poison
☐ GI -Bleed	☐ Asthma Symptoms	☐ Obvious Death
☐ GI -Constipation	☐ Hyperventilation	☐ Hemorrhage-(severe medical)
☐ GI -Diarrhea	☐ Dyspnea-SOB	☐ Shock
☐ Vomiting	☐ Apnea	☐ Trauma Injury (matrix)
☐ Vomiting Blood	☐ Cough W/Blood	☐ Post-Op Complication
☐ Nausea	☐ Airway Obstruction	☐ Eye Symp.(no trauma)
☐ Dehydration Symp.	☐ Pulmonary Edema	☐ Restraints Required
☐ Urinary Bleeding	☐ Pneumonia Symptoms	☐ Monitoring Required
☐ Urination Problem	☐ Respiratory Failure	☐ Seclusion Required
☐ Anxiety	☐ Respiratory Arrest	Special Handling
☐ Behavioral Disorder	☐ Newborn	☐ Isolation Required
☐ Depression (acute)	☐ Ob / Gyn	☐ Orth. Device Required
☑ Dizziness	☐ OB-GYN (complicated)	☐ Positioning Required
☐ Weakness	☐ Flu Symptoms	☐ Unknown Medical
☐ Psychiatric Emerg.	☐ Elevated Temp./Fever	☐ No Medical Problem
☐ Headache (no trauma)	☐ Sore Throat	(1) Other PI (2)
☐ Migraine	☐ Nose Bleed (severe)	
☐ Alt. Level Conscious	☐ Allergic Reaction	
☐ Seizure	☐ Medication Reaction	1°Protocol: 416
☐ CVA/Stroke *	☐ Diabetic Symptoms	
☐ Unconscious	☐ Back Pain (no trauma)	2°Protocol:
☐ Cardiac Symptoms	☐ Hyperthermia	
☐ Chest Pain	☐ Hypothermia	
☐ Syncope / Fainting	☐ Poisoning	

Mechanism of Injury (X all that apply)

☐ Alcohol Intox. Suspect	☐ Fall 2X Height
☐ Alcohol Intox Severe	☐ Fall > 20 ft
☐ Animal Bite	☐ Fall
☐ Assault Firearms	☐ Fight / Brawl
☐ Assault Sexual	☐ Fire
☐ Assault Stabbing	☐ Hazardous Materials
☐ Bicycle Accident	☐ Machinery
☐ Blunt Trauma	☐ Mod. Device Failure
☐ Burn/Scald-Non Fire	☐ MVA / Bicycle *
☐ Diving Injury	☐ MVA / Fixed Object *
☐ Near Drowning	☐ MVA / MVA *
☐ Drug Overdose	☐ MVA Non-Traffic *
☐ Elderly Abuse	☐ MVA to Pedestrian *
☐ Electrocution	☐ Smoke Inhalation
☐ Excessive Cold	☐ Suicide
☐ Excessive Heat	☐ NA
	☐ Unknown

Injury Intent: ☐ Unintentional ☐ Unknown — Other MOI: ☐ Intentional ☐ N/A ☐ Intentional Self

Injury

	Major / Internal Injuries ?	Amputation	Penetrating	Bleeding	Bruising	Burn	Dislocation	Fracture	Pain	Laceration	Paralysis / Numbness	Swelling	Soft Tissue Injury
Head													
Face													
Eye													
Neck													
Chest													
Back													
Shoulder													
Upper Arm													
Elbow / Forearm													
Wrist													
Hand													
Fingers													
Abdomen													
Pelvis / Hip													
Genitals													
Upper Leg													
Knee													
Lower Leg													
Ankle / Foot													
Toes													

Chief Complaint:

SH6001 (1 of 2), Rev 10, 02/06

(Page 1)

Unit Measure: 1 gm 4 mcg 7 mcg/min 10 LPM 13 mcg/kg/min | 2 mg 5 unit 8 gtt/min 11 ml/hr 14 units/hr | 3 meq 6 ml 9 mg/min 12 joules 15 Inch

Route: IV IM ETT RECtal | IO SQ NEB INHal | SL PO AUTo TRAnsdermal

5581845

Time	Staff #	Systolic B/P	Diastolic	PAL	Pulse	Respiration	SPO2	CO2	Blood Sugar	Pain (0-10)	Temperature
2145	1	160	120	☐	120	20					.
2155	2	1[illegible]6	110	☐	118	20					.
				☐							.
				☐							.

Treatment / Medication	Time	Staff #	Treat. Code	Med. Code	Dose	Unit	Route	Attempt	Cond.	Comments
								U ☐+ ☐-		

Narrative History: Key Words- (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications, Other Vital Signs)

Illness / Injury Onset Date: 10/31/09

Medical need (Must be supported in documentation): ☑ Medically Necessary ☐ Bed Confined ☐ Required Stretcher ☐ Unconscious ☐ Severe Pain ☐ Needed Restraining ☐ Visible Bleeding ☐ Non-Ambulatory

PMH ☐ Asthma ☐ Amputee ☐ Chronic Renal Failure ☐ Chronic Respiratory Failure ☐ Cancer ☐ Cardiac ☐ CVA / Stroke ☐ Diabetes ☐ Dialysis ☐ Emphysema ☐ HIV / AIDS ☐ Hypertension ☐ Psychiatric Problems ☐ Seizure Disorder ☐ Substance Abuse ☐ Tracheostomy ☐ Tuberculosis ☐ Other

Allergies ☒ No

Medication denies

34 y/o male found ambulatory alert and oriented pt states he has abd pain, nausea and dizziness, pt states he took Nyquil this evening, pt denies taking any other meds, upon obtaining vitals pt has ↑BP pt denies med hx, upon entry of ESU NYPD [illegible] 3 and [illegible] 513 pt was aggitated and resistant, pt was [illegible] placed in custody and assisted onto stretcher for [illegible] Capt. [illegible] pt [illegible] reveals patent airway, neg SOB, neg cyanosis, [illegible] clear ⊜ bilat neg chest pain, abd soft x4 quads, pos nausea [illegible], neg vomiting, pos distal pulses [illegible] sensory x4 [illegible], pt [illegible] to hosp 34 W[illegible], (Before pt was detained pt walked down w/ [illegible] and NYPD, as pt approached bus he turned around stated he did not need help and walked away, pt was then detained and transported. Pt is [illegible] officer w/ 81 PCT)

Moved to Ambulance By: ☒ Chair ☐ Stretcher ☐ Scoop Stretcher ☐ Carried ☐ Walked with Assist ☐ Met at Ambulance

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☐ Prone ☒ Semi / Full Fowlers ☐ Left Lateral Recumbent

Medication / Treatment Authorization: ☒ Protocol ☐ On-Line ☐ Written Orders ☐ NA ☐ On-Scene | On-Line Physician | On-Line Med. Facility

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

Agency Definable 1 ... 2

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. Patient: ☐ Unable to Sign ☐ Refused to Sign ☐ PCS Collected ☐ Other Insurance Collected

Authorization Signature: Date: Guarantor Signature:

Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information.

Privacy Notice Signature: Date:

Patient's Physician Name (please print): | Receiving RN / MD Signature: [signature] | Technician Signature: Jessica [illegible] [signature]

I Refuse Treatment / Transportation and understand the consequences of my refusal: | Witness Signature for Refusal: | On-Line Medical Control Signature:

JHMC 42

JAMAICA HOSPITAL MEDICAL CENTER

1/3

CONSULTATION REPORT

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
081X STAFF, PHYSICIAN
ADM: 10/31/2009 **130381015** 01

THIS SECTION TO BE FULLY COMPLETED BY THE REQUESTING PHYSICIAN		
REQUEST TO: Dr. Patel / Dr. Lwin	DEPT/DIVISION: Psychiatry ER	
REQUEST FROM: Dr. Nwaishienyii	DEPT/DIVISION: Medical ER	
IMPRESSION: psychotic disorder, NOS		
REASON FOR CONSULTATION:		
☐CONSULTATION ONLY	☐CONSULTATION WITH ORDERS	☐CONSULTATION WITH FOLLOW-UP
SIGNATURE:	DATE: 11/1/09	TIME: 6:30 am

OPINION OF CONSULTANT:

34 years old single white male, police officer, living by himself was brought in by NYPD of 81st Precint, in hand cuff to Medical ER with complaint of abdominal pain, nausea and dizziness and patient stated he took Nyquil.

Psych consult was called and reported as patient acting bizzare, hand cuffed and in Police custody.

As per patient, he was not feeling well yesterday, had "tummy pain / Abdominal pain and told his supervisor that he is leaving. Patient says while sleeping in his bed, landlord open the door and his colleagues entered and hand cuffed and brought him to Jamaica hospital. He says he is worried about the situation going on. Says this is happening because he has been reporting to his superiors and commissioner about internal affairs of police department. Says he knows his ~~superior~~ KL supervisors are hiding robbery and assault cases to get higher ranker / position. Says he has paper documentation about this crime and reporting since last year.

→ continue

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 110 ITEM: 849 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER 1/3

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

Denies past psy hospitalization(or) treatment (or) suicidal attempt.
As per Sargent James of 81st Precint, patient complains of not feeling well yesterday afternoon and left his work early after getting agitated and cursing supervisor. They follow him home and he had barricaded himself and the door had to be broken to get to him. He initially agreed to go with them for evaluation but once outside, he ran and had to be chased and brought to the medical ER, handcuffed.
In the medical ER, he became agitated, uncooperative and verbally abusive over telephone use and told his Treating MD that 'they are all against me'. As per i.c.
As per Sergeant James, he was evaluated by NYPD psychiatrist and can not carry a gun or a badge for nearly a year.
Denies any drug (or) Alcohol abuse
Denies any history of family mental illness
No acute medical problem. complained of abdominal pain yesterday and has rhinnitis.
Mental status Examination - 34 years old, white male appropriately dressed and groomed, appears to his stated age. He is coherent, relevant with goal directed speech and good eye contact. He is irritable with appropriated affect. He denies hallucination. He is ? paranoid about his supervisors. He denies suicidal ideation, homicidal ideation at

Cont.

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 112 ITEM: 1875 REV. 1/07 JHMC 44

JAMAICA HOSPITAL MEDICAL CENTER (3/3)

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

the present time. His memory and concentration is intact. He is alert and oriented. His insight and judgement are impaired.

Diagnosis

Axis I - psychotic disorder, NOS
II - deferred
III - s/p Abdominal pain, chronic sinusitis
IV - conflict at worksite
V - 40

Recommendation

① continue 1:1 observation for unpredictable behaviour and escape risk
② Transfer to psy ER after medical clearance
③ Discussed with Dr. Nwaishianyi and Sergeant James
Case discussed with Dr. Patel.

Khin Mar Lwin, MD
Psychiatric Resident

11/5/09 Concur w above Dr c Tx recommendations.
6 pm

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 112 ITEM: 1875 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER

PATIENT CLOTHING/VALUABLES INVENTORY

1. ALL PATIENTS CLOTHING/VALUABLES/SENT HOME ☐ YES ☑ NO
2. DENTURES TAKEN HOME BY FAMILY MEMBER ☐ YES ☐ NO

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

		ADMISSION		TRANSFER		TRANSFER	
		DATE/TIME: 11-01-09		DATE/TIME:		DATE/TIME:	
UNIT Overnight Ed		ROOM		ROOM	TO		
INVENTORY OF ITEMS KEPT AT BEDSIDE		QUANTITY	DESCRIPTION	QUANTITY	DESCRIPT.		
DENTURES	UPPER DENTURE		LABELED CUP PROVIDED ☐				
	LOWER		LABELED CUP PROVIDED ☐				
	PARTIAL		LABELED CUP PROVIDED ☐				
CLOTHING/ OUTWEAR/ FOOTWEAR	COAT/JACKET						
	DRESS/HOUSECOAT						
	PAJAMAS/NIGHTGOWN						
	SLACKS/PANTS/JEANS						
	~~BLOUSE~~/T-SHIRT/~~SWEATER~~						
	SKIRT/SHORTS						
	UNDERWEAR/~~BRA~~						
	GLASSES/CONTACTS						
	HAT/~~GLOVES~~/TIE/BELT						
	~~PANTYHOSE~~/SOCKS						
	BATHROBE						
	~~SHOES~~/SNEAKERS						
	BOOTS/SLIPPERS						
MISCELLANEOUS	POCKETBOOK						
	CELL PHONE/BEEPER(S)						
	WALKER/CANE						
	HEARING AID						
	OTHER:						
JEWELCRY: DESCRIPTION	BRACELET (S)						
	EARRING (S)						
	NECKLACE (S)						
	RING (S)						
	WATCH						
	OTHER:						
MONEY AMOUNT			$		$		
	VALUABLES SUBMITTED TO THE CASHIER AND VALUABLES PLACED						
	GLASSES/CONTACT(S)						
	HEARING AID						
	~~POCKETBOOK~~/ WALLET						
	RADIO						
	CELL PHONE/BEEPER						
	OTHER:						
	ENVELOPE RECEIPT #		83323				

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expwy.
Jamaica, N.Y. 11418

83323

THE DEPOSITOR HEREBY ACKNOWLEDGES THAT THE DEPOSIT ENVELOPE HAS BEEN RETURNED TO THE DEPOSITOR INTACT AND SEALED

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015
STAFF, PHYSICIAN

S ARE WITHDRAWN AND DELIVERED TO OWNER.)

Name _____ Si

Address _____

This slip serves as receipt for deposit.

** PLEASE NOTE THE INSTITUTION IS NOT RESPONSIBLE FOR ITEMS LEFT AT THE PATIENT'S BEDSIDE(Print Name/Sign Below)

PATIENT/SIGNIFICANT OTHER:	PRINT NAME/SIGN:	PRINT NAME/SIGN:	PRINT NAME/SIGN:
STAFF RECEIVING PROPERTY	SIG/TITLE:	SIG/TITLE:	SIG/TITLE:
WITNESS/TRANSFERRING STAFF:	SIG/TITLE:	SIG/TITLE:	SIG/TITLE:

NOTE: VALUABLES WILL BE HELD IN SECURITY/CASHIER FOR NO MORE THAN 30 DAYS AFTER DISCHARGE

SECURITY/CASHIER SIGNATURE: PRINT NAME/SIGN:

STAFF MEMBER RELEASING PROPERTY: PRINT NAME/SIGN:

PATIENT/FAMILY MEMBER RECEIVING PROPERTY: PRINT NAME/SIGN: RELATIONSHIP:

22731-FORM 554 White Copy : Medical Record Yellow Copy: Nursing Pl

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of information:

I hereby authorize and direct Jamaica Hospital having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or Authorized Representative

Assignment to Jamaica Hospital

I hereby assign, transfer, and set over to Jamaica Hospital sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

Date

Signature of Insured or Authorized Representative

Safe Medical Device Act

I consent to the provision of my social security number to the manufacturer of any device that must betracked pursuant to the mandates of the Safe Medical Device Act. I understand that the manufacturer will be given my social security number only for the purpose of finding me in the event that a medical device, which is implanted in my body, or used in my home is defective.

Date

Signature of Insured or Authorized Representative

Patient Entitled to Medicare Benefits

I certify that the information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

Date

Signature of Insured or Authorized Representative

Financial Agreement

For and in consideration of services rendered or to be rendered by the *Jamaica Hospital*, to the patient whose name appears below, the undersigned (jointly and severally, if more than once) hereby agree(s) to be fully and totally responsible to the hospital for payment of all charges as submitted by the Hospital on the account of said patient and make payment in accordance with the policy of payment of bills at said Hospital. It is further agreed that the charges as incurred represent the fair and reasonable value of services rendered and are in accordance with the posted charges of the Hospital which are available upon request. Payment may be demanded at any time, and failure to demand payment of the patient shall not be a prerequisite to my (our) immediate responsibility for payment.

The undersigned has read the above, been informed of its nature and significance and acknowledges the contents of same and has received a copy of this agreement.

Dated

Guarantor

SCHOOLCRAFT, ADRIAN
Name of Patient

Address - Guarantor

10/31/2009 23:03
Hospital No. Date of Admission

Telephone - Guarantor

Date of Discharge

Witness Date

FORM NO. J00123
JHMC 47

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X 01 130381015
STAFF, PHYSICIAN

CONSENTS

PERMISSION FOR TREATMENT

I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THE PATIENT WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

GUARANTEE OF PAYMENT

FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT.
I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TREATMENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

AUTHORIZE OF PAYMENT

I HEREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X
STAFF, PHYSICIAN 01 130381015

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative

Relationship to patient

Date

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice Privacy Practices at this time.

Signature of patient or authorized representative

Relationship to patient

Date

THIS FORM IS PART OF THE MEDICAL RECORD

JAMAICA HOSPITAL MEDICAL CENTER

Jamaica Hospital Medical Center
8900 Van Wyck Expressway, Jamaica, New York 11418
Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, heath maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name this ___ day of _____, 200 __.

YOU SIGN HERE: _____

PRINTED NAME: SCHOOLCRAFT ADRIAN

ADDRESS: _____

MEDICAL RECORD # 1298984

WITNESS: _____

PRINT NAME/TITLE: _____

ADDRESS: 8900 Van Wyck Expressway, Jamaica, New York 11418

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

This release is valid for one year from _____ (today's date).

_____
Signature of Patient (or legal representative) (Date)

_____
Description of legal representative's authority to act on behalf of the patient.

Patient's Health Plan ID#: _____

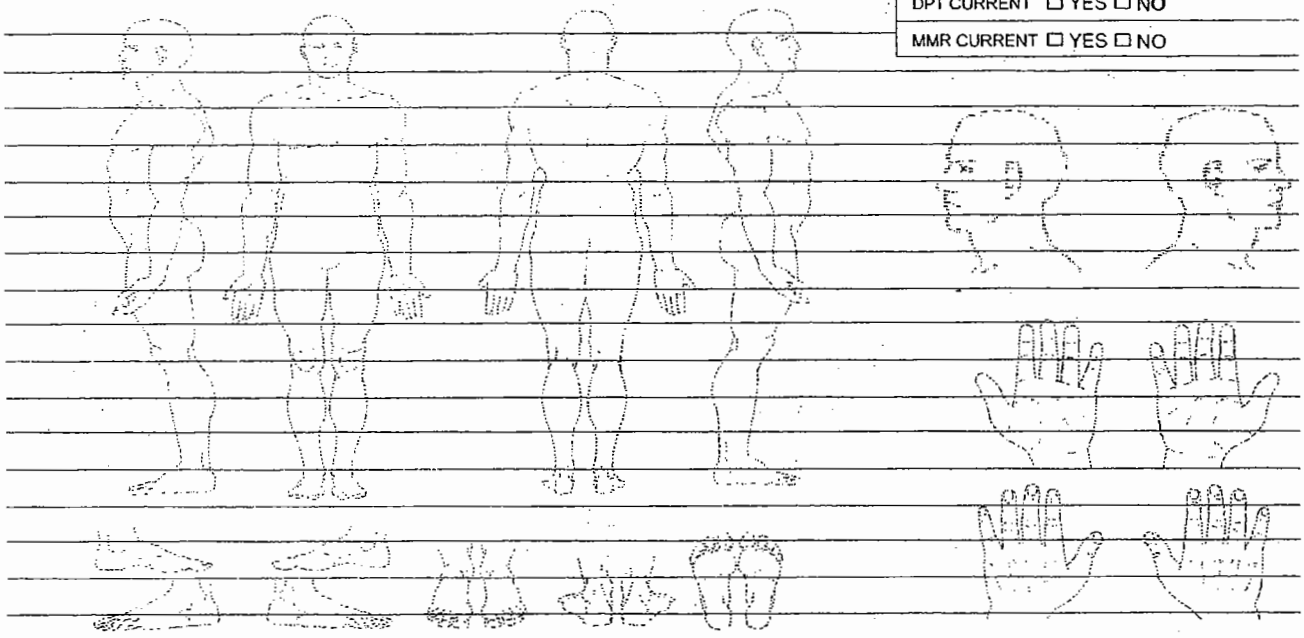
If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.

Form No. J00027
JHMC 51

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X 01 130381015
STAFF, PHYSICIAN

DATE		HISTORY & PHYSICAL
TIME		

ACTION IF NOT CURRENT:
- DT CURRENT ☐ YES ☐ NO
- DPT CURRENT ☐ YES ☐ NO
- MMR CURRENT ☐ YES ☐ NO



IMPRESSIONS

PHYSICIAN NAME (PRINT) I D #

PHYSICIAN NAME (SIGN)

LAB TESTS	RESULTS TIME	RESULTS TIME
☐ HGB		
☐ HCT		
☐ WBC		
☐ NA		
☐ K		
☐ CL		
☐ CO_2		
☐ BUN/CR	/	/
☐ GLUC.		
☐ AMYLASE		
☐ PT/PTT		
☐ UCG		
☐ CPK		

U/A
RBC___ WBC___ Prot___
BLD___ KET___ GLU___

BLOOD GASES	TIME	TIME
PH		
PO_2		
PCO_2		
HCO_3		
HBO_2		
HGB		
HGCO		

EKG RESULTS

RADIOLOGY
X-RAY # ED READING

☐ CHEST	
☐ ABDOMEN	
☐ C-SPINE	
☐ L-SPINE	
☐ PELVIS	
☐ TIBIA/FIBULA __L __R	
☐ FEMUR __L __R	
☐ WRIST __L __R	
☐ ANKLE __L __R	
☐ HIP __L __R	
☐ CT SCAN	
☐	

CONSULTANT NAME SERVICE TIME CALLED
1.
2.
3.

ADDITIONAL MD NOTES

FINAL DIAGNOSIS CODE

DISPOSITION

☐ ADMITTED, TIME:___ ROOM #___ SERVICE ___ ☐ FAMILY MEMBER NOTIFIED___ NAME, RELATIONSHIP

☐ EXPIRED, TIME:___ ☐ M.E. CALLED, TIME:___ ACCEPTED ☐ YES ☐ NO CASE #___

☐ DISCHARGED, TIME:___ ☐ INSTRUCTIONS GIVEN (TYPE)___ ☐ PVT MD NOTIFIED OF DISPOSITION

☐ OTHER ___ (AMA, WALK-OUT, TRANSFER) TIME:___ TIME:___ INITIALS

CONDITION ON DISCHARGE ___

DISCHARGING PHYSICIAN NAME (PRINT)___ SIGNATURE___ I D #___ DATE___

FILE

EMERGENCY DEPT COPY FORM NO. J00018

JHMC 52

Patient Fact Sheet

Name and Address
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Phone: (718)570-6224 **Sex:** M
SS No: 469-97-6997 **Marital Status** S
Race: W **Religion:** NO
BirthDate: 6/21/1975 **Occupation:** UNEMPLOYED
Patient's Maiden Name:

Employer
UNEMPLOYED
Phone: (999)999-9999

Nearest Relative
SCHOOLCRAFT, SELF
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone: (718)570-6224 **Rel:** 01
Business Phone:

Admission Data

Account Number	Unit Number
130381015	1298984

Admit Date	Admit Time	ER MD
10/31/2009	23:03	FF, PHYSI

Triage Time	Prim Care MD
	NA

Guarantor
SCHOOLCRAFT, ADRIAN
82 60 88 PL
RIDGEWOOD NY 11385
Home Phone (718)570-6224
Business Phone
Rel: 01 **SS:** 999-99-9999
Occ: UNEMPLOYED
Employer UNEMPLOYED

Emergency Contact
SCHOOLCRAFT
Home Phone: (718)570-6224 **Rel:** 01
Business Phone:

Insurance Information
Ins: NO COVERAGE/CHARITY CA **Insured:** SCHOOLCRAFT, ADRIAN
Policy Number: **Group Number:** **Rel:** SELF/
82 60 88 PL
RIDGEWOOD NY 11385
Phone Number (718)570-6224 **FIN** 99
Auth Number

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

ID 130381015

Jamaica Hospital Medical Center

Emergency Department Record

History of Present Illness

SNW

34 Year Old Male Patient Presents with Abdominal Pain Epigastric for 15 Hour(s). The Onset is Sudden. The symptoms are Mild, sharp, Intermittent, unknown duration. Symptoms improve with without treatment. Additional Symptoms or Pertinent History also involve None. Furthermore, the Patient/Family Denies Anorexia; Fever; Genital Pain; Back Pain;. Patient states exacerbating Factors that occur are unknown. Radiating Symptoms include No Radiations. Patient is a Police Officer brought in handcuff by his colleagues.As per Patient he wasn't feeling well about 15hrs ago and at about 2 pm he told his superiors that he was leaving for home.His colleagues from his Prescinct went to his home and hand cuff because the EMS said Patient was behaving irrationally.

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU Neg	Neuro Neg	ENT Neg	Resp Neg	Musculoskeletal Neg	Hematologic/Lymphatic Neg
Skin Neg	Psych Neg	Heart Neg	GI Neg	Endocrine Neg	Allergic/Immunologic Neg
☑ All other ROS negative				Constitutional Sxs Neg	Eyes Neg

☑ Vital Signs/Triage/Nursing Notes Reviewed and Agree ☐ Hx unobtainable due to Tx urgency or poor historian(s) ☐ Additional Information from Police, Ambulance, Nursing Home or Relatives ☐ Old Medical Records Reviewed

Past Medical History ☑ No Relevant PMHx ☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA

Other PMHx ☐ Diabetes ☐ HTN ☐ Psychiatric ☐ Renal ☐ Seizures

Social History ☑ No Relevant SoHx ☐ ETOH ☐ Drugs ☐ Smoking Additional Sx

Family History ☑ No Relevant FmHx No Significant FMHx

Physical Exam

Exam Time 0:05

SNW

General Appearance	Awake A&Ox3
HEENT	PERRL EOMI Moist Mucous Membranes No Icterus
Chest	RRR No M Lungs CTA No Ret Chest Wall NT
Abdomen	No Pulsating Masses BS-NL/No Bruits Tenderness-None
GU	
Extremities	Throughout all extremities erythematous impressions on the wrist bilaterally at the site of handcuffs application CBR < 2 sec Active ROM-Full mild tenderness on the wrist where the hancuffs were applied
Neuro	
Skin	No pallor/ rashes warm & moist
Back	NT no CVAT, Back Flexion 90
Neck	NT Full ROM No JVD
Lymphatics	No LAD

Repeat or Additional Clinical Notes

MD	Notes	Time	
SNW	The following Life or Limb Threatening Differential Diagnosis were considered: Appendicitis; AAA Leaking or Rupture; Incarcerated Hernia; Mesenteric Ischemia or Thrombosis; Myocardial Infarction or CAD; Testicular Ovarian or Salping Torsion; Large or Small Bowel Volvulus; Liver Failure Pancreatitis; Rupture Viscous (Liver Spleen Bowel); Intraabdominal Abscess; Ectopic Pregnancy; Intussusception; Hemolytic Uremic Syndrome;	11/1/2009	0:03
SNW	Looks Comfortable; Not Ill Appearing; No Peritoneal Signs; Genitals Non Tender; No Hernias; No Pulsating Masses; Murphy's Sign Negative; McBurneys & Rovsing Sign Neg; Femoral Pulses 2+ Bilaterally; Psoas Sign Negative; Obturator Sign Negative;	11/1/2009	0:03
SNW	Pt Sx(s) improving. No Sx(s) or Objective findings that are life or limb threatening. Medically Screened and Stable for disposition(Transfer) from the ED.	11/1/2009	0:14

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

SNW	Psychiatry consult called	11/1/2009	1:43
SNW	Patient seen by Psychiatry team led by Dr Patel who recommended transfering Patient to Psychiatry ER after medical clearance	11/1/2009	6:50

Patient Name SCHOOLCRAFT, ADRIAN Medical Record No. 1298984

Account Number 130381015 Date 10/31/2009

Diagnostics

Specimen Collected / ECG ,Rad Ordered

MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
GLE	10/31/200 23:10	Pulse Ox	97%	SN	GLE	23:10
SNW	11/1/2009 0:12	Amylase	Amylase-44,Status-FINAL	SN	VCA	0:14
SNW	11/1/2009 0:12	Troponin	Cancel	SN	VCA	0:14
SNW	11/1/2009 0:12	CBC	WBC-12.3,Hgb-14.8,Hct-44.0,Platelets-251,Neut-82.4,Lymph-11.0,Eos-0.2,Baso-0.7,Mono-5.7,MCH-29.4,MCHC-33.6,MCV-87.6,MPV-8.5,RBC-5.02,RDW-13.7,Abs Baso-0.1,Abs Eos-0.0,Abs Lymph-1.3,Abs Mono-0.7,Abs Segs-10.1,Smear Review-Completed,Nucleated RBC-0,NRBC Inst.-0.00,Status-FINAL	SN	VCA	0:14
SNW	11/1/2009 0:12	Chem 20/CMP	AGPK-14.10,Na-138,K-4.1,Cl-104,CO2-24,BUN-14,CR-1.0,Glucose-94,Ca-9.4,AST-46,ALT-51,Alk Phos-57,Albumin-4.7,T-bili-0.6,Protein-8.2,Anion Gap-10.00,Status-FINAL	SN	VCA	0:14
NRI	11/1/2009 0:22	Lipase	Lipase-55,Status-FINAL	SN	NRI	0:33

Medical Orders

MD Initials	Time	Order	RN Initials	Time	Location-Response-Quantity	RN Remarks
SNW	11/1/2009 0:14	Heplock	VCA	0:14		

MD Procedures

Procedure Description	Comments
Time 6:57	MD GLE
Pulse Ox	94760-26 CPT

Recommended LOS/CPT/ICD-9 Code

Physician's LOS = 4 99284-26

Nurse's LOS = 5 612 APC

Diagnoses

Abdominal Pain	789.00 ICD-9
Psychosis NOS	298.9 ICD-9

	MD	MD Time		RN	RN Date/ Time	Admit to
Disposition	SNW	6:56	Transfer Psychiatric ED	VCA	11/1/2009	6:58
Condition	SNW	6:56	Stable	VCA	6:58	

Physician (Print) Nwaishienyi, Silas (MD)

Physician Signature 

Other Physicians

Nwaishienyi, Silas (MD)~Lwin, Khin Mar (RES)

Patient Name **SCHOOLCRAFT, ADRIAN**

Medical Record No. **1298984**

Account Number **130381015**

Date **10/31/2009**

Primary RN (Print) Calderone, Virnalyn (RN)

Other Nurses

Ledbetter, Glenda (RN)~Calderone, Virnalyn (RN)~Shankar, Koesmawatie (PIR)~Rinehart, Nedie (RN)~Ward, Germaine (Reg)~West, Juanita (RN)~Charran, Donna (PIR)~Paris-Taylor, Elyane (WC)~Bido-Rosa, Ana (Reg)~Stancu, George (Clerk)

This chart has been electronically signed via the EmpowER software.

Patient Name **SCHOOLCRAFT, ADRIAN** Medical Record No. **1298984**

Account Number **130381015** Date **10/31/2009**

Jamaica Hospital Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEntered: 11/1/2009 4:52 **Vitals Taken By:** NRI

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 98.0	Right	81	R 125/77	21	100%	Discomfort 1 - 2
T	Left		L			
R						

Nursing Notes

Time Note Entered		RN Initials	Note
11/1/2009	0:00	VCA	Brought in per stretcher by EMT on Police custody.A & O x3. Unlabored resp.(+)Left Lower quadrant abd. Pain 3-4/10 x 15 hrs ago.Denies nausea & vomiting.Abd, soft, non-tender. BS(+)normoactive. Skin warm, moist, intact. w/ good capillary refill.
11/1/2009	2:00	NRI	Noted w/ redness on the Rt wrist with the hand cuff.Polce officer made aware.& requested to loosen a ittle bit yet refused.Will closely monitor for poor circulation.
11/1/2009	4:39	NRI	pt. Resting;A & O x 3. no distress.waiting for evaluation and disposition.under police custody.
11/1/2009	5:54	VCA	Psyche consult in progress w/ recommendation to transfer to Psyche ED until medically cleared.Pt. Verbalized, "My wrist is numb, I dont feel anything right now."Encouraged to stay still on bed.Avoid unneccessary movements.Conversant to his father by phone.
11/1/2009	6:58	VCA	Psyche ED made aware of pt. For transfer.ML pulled out.Awaiting transfer.

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved
Comfort, Altered	Demonstrate Decrease S & S	

Primary RN (Print) Calderone, Virnalyn (RN)

Jamaica Hospital Medical Center Triage

Category: 3 ESI-3 (Urgent)

Arrival Date/Time	Triage Time	Waiting Rm Time	Exam Rm Time
10/31/2009 23:03	23:03		23:03

PCP Staff Status: None | Family Physician: NA | Transported by: JHMC Ambulance | Mode: Stretcher

Historian: Self

Police Dept: Custody Yes | Notification | Beat # PCT- 81, #27009

Chief Complaint: Abdominal Pain (Lower)

Onset Time: 14 Hour(s) **Location:**

Associated Sxs / Pertinent History

Denies vomiting and diarrhea. Pt under police custody, Pt became anxious with increased BP @ the scene.

Past Medical Histor Additional:

- [x] No Significant PMHx
- [ ] Asthma [ ] COPD [ ] CAD [ ] Cancer [ ] CHF [ ] CVA
- [ ] DM [ ] HTN [ ] Psych [ ] Renal [ ] Seizures [ ] Substance Abuse

Medications

- [x] No Meds [ ] Unknown

Allergies

No Known Drug Allergies

Immunizations UTD? UTD

TB Hx, PPD Pos or Infectious Exposures? No

**If yes to TB or Infectious question take precautions*

Mental Status / Psychological Eval

Alert Oriented

Lung Sounds

	R	L
Clear	☑	☑
Diminished	☐	☐
Wheezes	☐	☐
Rales	☐	☐
Rhonchi	☐	☐
Retractions	☐	☐

Eyes

	R	L
Equal	☐	☐
Reactive	☐	☐
Fixed	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Cataract	☐	☐

Glasgow Coma Scale

Eye

Verbal

Motor

Total 0

Skin

Color Normal

Temp Normal

Moist Normal

OB/Gyn

G	P	Ab	Miscarriages
0	0	0	0

Extremities

Pulses

ROM

Nutrition

Normal

Fall Risk Assessment

No Fall Risks Identified

Suicide Risk Assessment

No nsk identified

Plan

A3-09 Time 23:03

Triage Nurse: Ledbetter, Glenda (RN)

Triage II: GLE

Triage III: GLE

Domestic Violence Assessment

Are you being hurt by someone you live with or who takes care of you?

Yes/No No

* Mandatory completion of Domestic Violence Referral.

Functional D/C Planning

Daily Living Independent

Living Conditions Alone

Going Home with Self

Assessing Patient's, Child's or Parent's readiness to learn

Primary Language English

Assessed Disability No Disability

Communication Barrier ☐

Language Translator ☐

Motivation Level Med

Knowledge Level Med

Comprehension Ability Med

Patient Name
SCHOOLCRAFT,ADRIAN

Medical Record Number
1298984

Account Number
130381015

DOB 06/21/1975

Age 34 Years

Gender Male

Vitals

Tem

Oral 99.0

Rectal

Tympanic

Pulse

Right

Left 115

Respirations

18

Blood Pressure

Right

Left 139/80

Pulse Ox

97%

Weight (Kg

109 Kg

Height Head Circumferenc

Pain Scale

Mild 3 - 4

☐ LWBS ☐ LW Completed Tx/ Eloped ☐ AMA ☐ AMA Refused ☑ Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

Patient Name SCHOOLCRAFT, ADRIAN Medical Record No. 1298984

Account Number 130381015 10/31/2009

Emergency Department Pharmacy and Supply Charges

Interventions

Intervention Name	Comments	Charge Code
Heplock		

Diagnostics

Diagnostic Ordered	Charge Code
Pulse Ox	0
CBC	0

Nurse LOS 5 612 APC **Charge Code** 0

Jamaica Hospital Medical Center

Medication Reconciliation

Patient Name	SCHOOLCRAFT, ADRIAN	Medical Record No.	1298984
Account Number	130381015	Date of ED Visit	10/31/2009

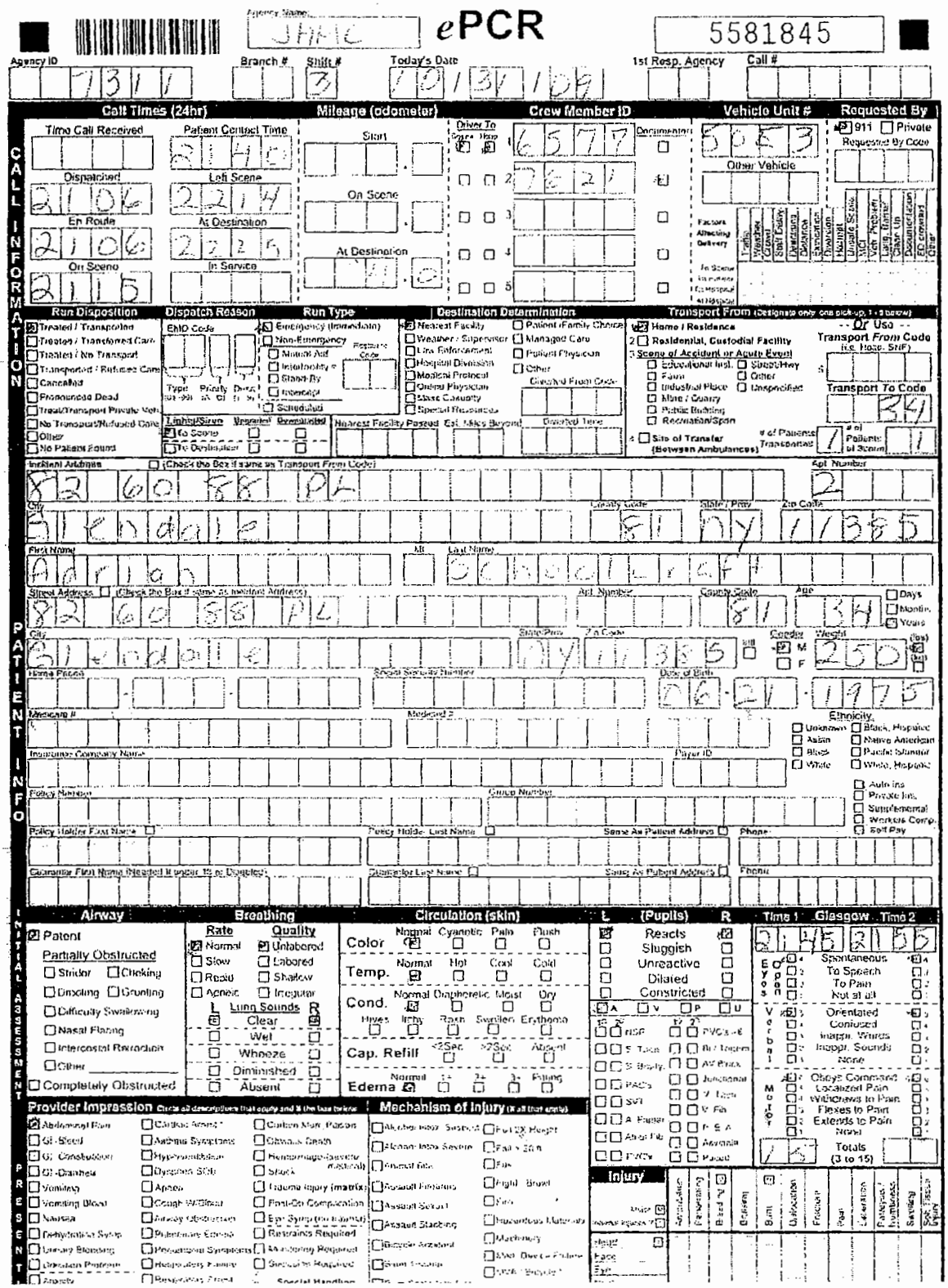
Allergies

No Known Drug Allergies

Home Medications

Medications Administered in the Emergency Department

Medication Prescription provided on Discharge



ePCR

5581845

Unit Measure				
1 gm	4 mcg	7 mcg/min	10 LPM	13 mcg/kg/min
2 mg	5 unit	8 gtt/min	11 ml/hr	14 units/hr
3 meq	6 ml	9 mg/min	12 joules	15 Inch

Route			
IV	IM	ETT	RECtal
IO	SQ	NEB	INHal
SL	PO	AUTo	TRAnsdermal

5581845

VITALS

Time	Staff #	Systolic B/P	Diastolic	Pulse	Respiration	SPO2	CO2	Blood Sugar	Pain (0-10)	Temperature
2145	1	160	120	120	30					
2155	2	160	110	118	20					

FLOW CHART

Treatment / Medication	Time	Staff #	Treat. Code	Med. Code	Dose	Unit	Route	Attempt Cond.	Comments

Narrative History: Key Words- (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications, Other Vital Signs) Illness / Injury: Onset Date 10 / 31 / 09

Medical need (Must be supported in documentation): ☒ Medically Necessary ☐ Required Stretcher ☐ Severe Pain ☐ Visible Bleeding ☐ Bed Confined ☐ Unconscious ☐ Needed Restraining ☐ Non-Ambulatory

PMH: ☐ Asthma ☐ Chronic Renal Failure ☐ Cancer ☐ CVA / Stroke ☐ Dialysis ☐ HIV / AIDS ☐ Psychiatric Problems ☐ Substance Abuse ☐ Tuberculosis ☐ Amputee ☐ Chronic Respiratory Failure ☐ Cardiac ☐ Diabetes ☐ Emphysema ☐ Hypertension ☐ Seizure Disorder ☐ Tracheostomy ☐ Other

Allergies ☒ No

Medication: denies

34 y/o male found ambulatory alert and oriented. pt states he has abd pain nausea and dizziness. pt states he took [illegible] this evening, pt denies taking any other meds. upon obtaining vitals pt has ↑BP, pt denies med hx [illegible] ESU [illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]

Moved to Ambulance By: ☒ Chair ☐ Scoop Stretcher ☐ Walked with Assist ☐ Stretcher ☐ Carried ☐ Met at Ambulance

Transport Position: ☐ Supine ☐ Shock ☒ Semi / Full Fowlers ☐ Sitting ☐ Prone ☐ Left Lateral Recumbent

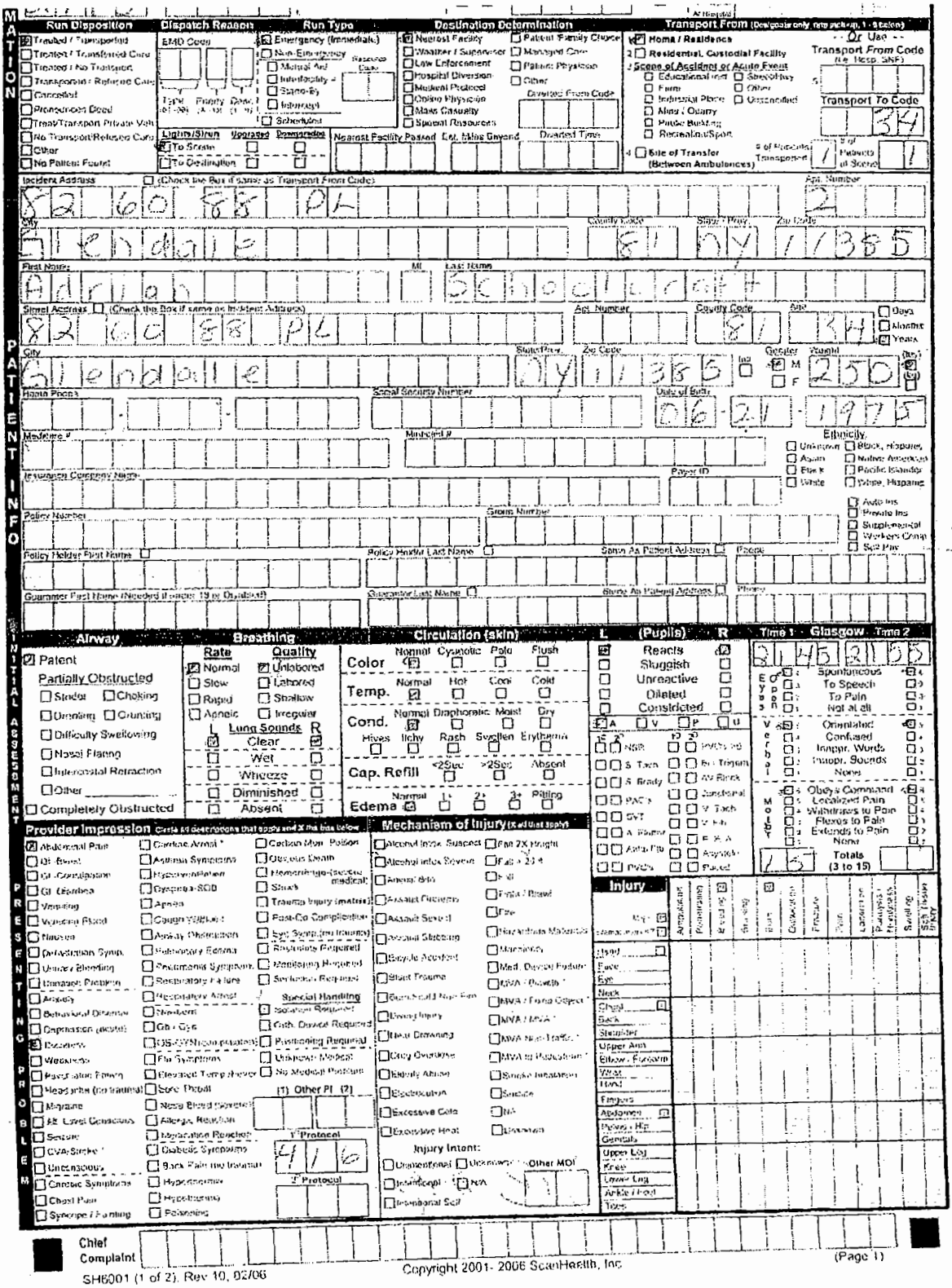
Medication / Treatment Authorization: ☒ Protocol ☐ Written Orders ☐ On-Line ☐ NA ☐ On-Scene; On-Line Physician; On-Line Med. Facility

SUPPLY

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

Agency Definable

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services and/or my insurance carriers and their agents, including any other information needed to determine these benefits...


PATIENT INFO
INITIAL ASSESSMENT
PRESENTING PROBLEM
Run Disposition
Dispatch Reason
Run Type
Destination Determination
Transport From
Transport To Code
Incident Address
Apt. Number
City
County Code
State / Prov
Zip Code
First Name
MI
Last Name
Street Address
Age
Gender
Weight
Home Phone
Social Security Number
Date of Birth
Medicare #
Medicaid #
Ethnicity
Insurance Company Name
Payer ID
Policy Number
Group Number
Policy Holder First Name
Policy Holder Last Name
Same As Patient Address
Phone
Guarantor First Name (Needed if under 19 or Dependent)
Guarantor Last Name
Same As Patient Address
Phone
Airway
Breathing
Rate
Quality
Lung Sounds
Circulation (skin)
Color
Temp.
Cond.
Cap. Refill
Edema
L (Pupils) R
Reacts
Sluggish
Unreactive
Dilated
Constricted
Time 1 - Glasgow - Time 2
Eyes
Verbal
Motor
Totals (3 to 15)
Provider Impression
Mechanism of Injury
Injury
Chief Complaint
SH6001 (1 of 2), Rev. 10, 02/06
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(Page 1)

JHMC 64

FLOW CHART

Narrative History: Key Words (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications, Other Vital Signs) | Illness / Injury Onset Date: 10 / 31 / 09

Medical need (Must be supported in documentation): ☒ Medically Necessary ☐ Bed Confined ☐ Required Stretcher ☐ Unconscious ☐ Severe Pain ☐ Needed Restraining ☐ Visible Bleeding ☐ Non-Ambulatory

PMH: ☐ Asthma ☐ Amputee ☐ Chronic Renal Failure ☐ Chronic Respiratory Failure ☐ Cancer ☐ Cardiac ☐ CVA / Stroke ☐ Diabetes ☐ Dialysis ☐ Emphysema ☐ HIV / AIDS ☐ Hypertension ☐ Psychiatric Problems ☐ Seizure Disorder ☐ Substance Abuse ☐ Tracheostomy ☐ Tuberculosis ☐ Other

Allergies ☒ No

Medication: denies

34 y/o male found ambulatory alert and oriented pt states he has abd pain, nausea and dizziness pt states he took Nyquil this evening, pt denies taking any other meds upon obtaining vitals pt has ↑BP pt denies med hx, [illegible] ESU, NYPD

[illegible]

NARRATIVE HISTORY

Moved to Ambulance By: ☒ Chair ☐ Stretcher ☐ Scoop Stretcher ☐ Carried ☐ Walked with Assist ☐ Met at Ambulance

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☐ Prone ☒ Semi / Full Fowlers ☐ Left Lateral Recumbent

Medication / Treatment Authorization: ☒ Protocol ☐ On-Line ☐ Written Orders ☐ NA ☐ On-Scene | On-Line Physician | On-Line Med Facility

SUPPLY

Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

Agency Definable 1 / 2

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. Patient: ☐ Unable to Sign ☐ Refused to Sign ☐ PCS Collected ☐ Other Insurance Collected

Authorization Signature | Date: | Guarantor Signature

Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information.

Privacy Notice Signature | Date:

Patient's Physician Name (please print): | Receiving RN/MD Signature: [signature] | Technician Signature: [signature]

I Refuse Treatment / Transportation and I understand the consequences of my refusal: | Witness Signature to Refusal: | On-Line Medical Control Signature:

646-957-2486 (FATHER)

FILE

LOCATION: 081X

3

JAMAICA HOSPITAL MEDICAL CENTER

8900 Van Wyck Expressway Jamaica, NY 11418

DATE AND TIME OF ARRIVAL 10/31/2009 23:03

EMERGENCY MEDICINE RECORD

REGISTRATION MEDICAL RECORD NO 1298984 PATIENT TYPE E PATIENT ACCOUNT NO. 130381015

PATIENT'S NAME		SOCIAL SECURITY NO.	DATE OF BIRTH	AGE
SCHOOLCRAFT	ADRIAN		06/21/1975	34Y

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO	PLACE OF BIRTH
X260 96 PL			11365	7186724	

FIN. CL	SEX	RACE	RELIGION	MARITAL STATUS	FATHER'S NAME	MOTHER'S MAIDEN NAME, FIRST NAME
01	M	W	N	S		

PRIVATE M.D. NAME OR CLINIC NAME	PATIENT COMPLAINT	LANGUAGE	INTERP. REQ.
		ENG	N

MODE OF ARRIVAL	ACCOMPANIED BY	RELATIONSHIP	TELEPHONE NO	INJURED AT WORK?	AUTO ACCIDENT?

DATE AND TIME OF ACCIDENT	POLICE OFFICER NAME & BADGE NO.	PCT. NO	REFERRED FROM: ☐ PMD ☐ TRUMP ☐ CLINIC ☐ FP ☐ OTHER

NEXT OF KIN	TELEPHONE NO.	NEXT OF KIN ADDRESS	RELATIONSHIP TO PATIENT

FINANCIAL - INSURANCE

GUARANTOR'S NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
W/C BK				

GUARANTOR'S SOC. SEC. NO	TELEPHONE NO	GUARANTOR'S EMPLOYER	ADDRESS	TELEPHONE NO.

PATIENT'S EMPLOYER NAME	STREET ADDRESS	CITY	STATE	ZIP CODE

INSURANCE #1: NAME GROUP NO. POLICY NO.

INSURANCE #2: NAME GROUP NO. POLICY NO.

HOSPITALIZED PAST 90 DAYS?	IF YES, WHERE AND WHEN?	PLACE OF ACCIDENT	CRIME VICTIM PCT. NO.	CRIME VICTIM COMPLAINT NO.

COMMENTS: 1/1 OBTG

NURSING

VITAL SIGNS

TIME	B.P.	PULSE	RESP	TEMP
TIME	B.P.	PULSE	RESP	TEMP

IF ORDERED, CHECK WHEN COMPLETED: ☐ OXYGEN GIVEN

☐ EKG INITIALS ☐ CARDIAC MONITOR INITIALS ☐ IV ANGIO# INITIALS FLUID INITIALS METHOD INITIALS

NURSES NOTES ☐ ADVANCED DIRECTIVES DISCUSSED HEALTH CARE PROXY ☐ YES ☐ NO AGENT'S NAME:

RN SIGNATURE

DATE	TIME	NON-MEDICATION ORDERS (EKG, LABS, CULTURES, ETC.)	MD SIGNATURE	RN SIGNATURE	TIME

MEDICATION ORDERS

DATE	TIME	MEDICATION	DOSE	ROUTE	MD SIGNATURE	RN SIGNATURE	TIME

ACCOUNTING DEPT COPY

FORM NO. J00018

JAMAICA HOSPITAL MEDICAL CENTER

1/3

CONSULTATION REPORT

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
081X STAFF, PHYSICIAN
ADM: 10/31/2009 130381015 01

THIS SECTION TO BE FULLY COMPLETED BY THE REQUESTING PHYSICIAN		
REQUEST TO: Dr. Patel / Dr. Lwin	DEPT/DIVISION: Psychiatry ER	
REQUEST FROM: Dr. Nwaishienyi	DEPT/DIVISION: Medical ER	
IMPRESSION: psychotic disorder, NOS		
REASON FOR CONSULTATION:		
☐CONSULTATION ONLY	☐CONSULTATION WITH ORDERS	☐CONSULTATION WITH FOLLOW-UP
SIGNATURE:	DATE: 11/1/09	TIME: 8:30 am

OPINION OF CONSULTANT:

34 years old single white male, police officer, living by himself was brought in by NYPD of 81st Precint, in hand cuff to Medical ER with complaint of abdominal pain, nausea and dizziness and patient stated he took Nyquil.
Psych consult was called and reported as patient acting bizzare, hand cuffed and in Police custody.
As per patient, he was not feeling well yesterday, had tummy pain / Abdominal pain and told his supervisor that he is leaving. Patient says while sleeping in his bed, landlord open the door and his colleagues entered and hand cuffed and brought him to Jamaica hospital. He says he is worried about the situation going on. Says this is happening because he has been reporting to his superiors and commissioner about internal affairs of police department. Says he knows his ~~superiors~~ KL supervisors are hiding robbery and arrault cases to get higher ranks / position. Says he has proper documentation about this crime and reporting since last year.

→ continue

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 110 ITEM: 849 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER 1/3

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X 130381015 01
STAFF, PHYSICIAN

CONSULTATION REPORT CONTINUATION

Denies past psy hospitalization(or) treatment (or) suicidal attempt.
As per Sergeant James of 81st Precint, patient complained of not feeling well yesterday afternoon and left his work early after getting agitated and cursing supervisor. They follow him home and he had barricaded himself and the door had to be broken to get to him. He initially agreed to go with them for evaluation but once outside, he ran and had to be chased and brought to the medical ER, handcuffed.
In the medical ER, he became agitated, uncooperative and verbally abusive over telephone use and told his Treating MD that 'they are all against me'. As per
As per Sergeant James, he was evaluated by NYPD psychiatrist and can not carry a gun or a badge for nearly a year.
Denies any drug (or) Alcohol abuse
Denies any history of family mental illness
No acute medical problem complained of abdominal pain yesterday and has rhinnitis.
Mental status Examination - 34 years old, white male appropriately dressed and groomed, appears to his stated age. He is coherent, relevant with goal directed speech and good eye contact. He is irritable with appropriated affect. He denies hallucination. He is ? paranoid about his supervisors. He denies suicidal ideation, homicidal ideation at

CWR.

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 112 ITEM: 1875 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER 3/3

SCHOOLCRAFT, ADRIAN
1288984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X
STAFF, PHYSICIAN 130381015 01

CONSULTATION REPORT CONTINUATION

the present time. His memory and concentration is intact.
He is alert and oriented. His insight and judgement are impaired.

Diagnosis
Axis I psychotic disorder, NOS
II deferred
III s/p Abdominal pain, chronic sinusitis
IV conflict at worksite
V 40

Recommendation
① continue 1:1 observation for unpredictable behaviour and escape risk
② Transfer to psy ER after medical clearance
③ Discussed with Dr. Nwaishianyi and Sergeant James
Case discussed with Dr. Patel.

Khin Mar Lwin, MD
Psychiatric Resident

11/1/09 [illegible] Dr. [illegible]
6 Am [illegible]

Consultant Print Name: Signature: Date: Time:

ORIGINAL - MEDICAL RECORD **CARBON COPY - CONSULTANT**

FORM: 112 ITEM: 1875 REV. 1/07

JAMAICA HOSPITAL MEDICAL CENTER

PATIENT CLOTHING/VALUABLES INVENTORY

1. ALL PATIENTS CLOTHING/VALUABLES/SENT HOME ☐ YES ☑ NO
2. DENTURES TAKEN HOME BY FAMILY MEMBER ☐ YES ☐ NO

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015 0
STAFF, PHYSICIAN

	ADMISSION	TRANSFER	TRANSFER
DATE/TIME:	11-01-09	DATE/TIME:	
UNIT	Breast Ca	ROOM ____ TO ____	
ROOM			

INVENTORY OF ITEMS KEPT AT BEDSIDE

		QUANTITY	DESCRIPTION	QUANTITY	DESCRIPT.
DENTURES	UPPER DENTURE	1	LABELED CUP PROVIDED ☐		
	LOWER		LABELED CUP PROVIDED ☐		
	PARTIAL		LABELED CUP PROVIDED ☐		
CLOTHING/ OUTWEAR/ FOOTWEAR	COAT/JACKET				
	DRESS/HOUSECOAT				
	PAJAMAS/NIGHTGOWN				
	SLACKS/PANTS/JEANS				
	BLOUSE/T-SHIRT/SWEATER				
	SKIRT/SHORTS				
	UNDERWEAR/BRA				
	GLASSES/CONTACTS				
	HAT/SCARF/TIE/BELT				
	PANTYHOSE/SOCKS				
	BATHROBE				
	SHOES/SNEAKERS				
	BOOTS/SLIPPERS				
MISCELLANEOUS	POCKETBOOK				
	CELL PHONE/BEEPER(S)				
	WALKER/CANE				
	HEARING AID				
	OTHER:				
JEWELRY/ DESCRIPTION	BRACELET (S)				
	EARRING (S)				
	NECKLACE (S)				
	RING (S)				
	WATCH				
	OTHER:				
MONEY AMOUNT			$		$

VALUABLES SUBMITTED TO THE CASHIER AND VALUABLES PLACED	
GLASSES/CONTACT(S)	
HEARING AID	
POCKETBOOK/ WALLET	✓
RADIO	
CELL PHONE/BEEPER	
OTHER:	
ENVELOPE RECEIPT #	83323

83323

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expwy.
Jamaica, N.Y. 11418

THE DEPOSITOR HEREBY ACKNOWLEDGES THAT THE DEPOSIT ENVELOPE HAS BEEN RETURNED TO THE DEPOSITOR INTACT AND SEALED.

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM:10/31/2009 081X 130381015 0
STAFF, PHYSICIAN

S ARE WITHDRAWN AND DELIVERED TO OWNER.)

Name _____ SI

Address _____

This slip serves as receipt for deposit.

** PLEASE NOTE THE INSTITUTION IS NOT RESPONSIBLE FOR ITEMS LEFT AT THE PATIENT'S BEDSIDE(Print Name/Sign Below)

PATIENT/SIGNIFICANT OTHER:			
STAFF RECEIVING PROPERTY			
WITNESS/TRANSFERRING STAFF:			

NOTE: VALUABLES WILL BE HELD IN SECURITY/CASHIER FOR NO MORE THAN 30 DAYS AFTER DISCHARGE

SECURITY/CASHIER SIGNATURE:

STAFF MEMBER RELEASING PROPERTY:

PATIENT/FAMILY MEMBER RECEIVING PROPERTY: RELATIONSHIP:

22731-FORM 554 White Copy : Medical Record Yellow Copy: Nursing Pl

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization to Jamaica Hospital for release of information:

I hereby authorize and direct Jamaica Hospital having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date _____ Signature of Patient or Authorized Representative _____

Assignment to Jamaica Hospital

I hereby assign, transfer, and set over to Jamaica Hospital sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

Date _____ Signature of Insured or Authorized Representative _____

Safe Medical Device Act

I consent to the provision of my social security number to the manufacturer of any device that must betracked pursuant to the mandates of the Safe Medical Device Act. I understand that the manufacturer will be given my social security number only for the purpose of finding me in the event that a medical device, which is implanted in my body, or used in my home is defective.

Date _____ Signature of Insured or Authorized Representative _____

Patient Entitled to Medicare Benefits

I certify that the information given by me in applying for the payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

Date _____ Signature of Insured or Authorized Representative _____

Financial Agreement

For and in consideration of services rendered or to be rendered by the *Jamaica Hospital*, to the patient whose name appears below, the undersigned (jointly and severally, if more than once) hereby agree(s) to be fully and totally responsible to the hospital for payment of all charges as submitted by the Hospital on the account of said patient and make payment in accordance with the policy of payment of bills at said Hospital. It is further agreed that the charges as incurred represent the fair and reasonable value of services rendered and are in accordance with the posted charges of the Hospital which are available upon request. Payment may be demanded at any time, and failure to demand payment of the patient shall not be a prerequisite to my (our) immediate responsibility for payment.

The undersigned has read the above, been informed of its nature and significance and acknowledges the contents of same and has received a copy of this agreement.

Dated _____ Guarantor _____

SCHOOLCRAFT, ADRIAN
Name of Patient

Address - Guarantor _____

10/31/2009 23:03
Hospital No. Date of Admission

Telephone - Guarantor _____

Date of Discharge

Witness _____ Date _____

FORM NO. J00123

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X 01 130381015
STAFF, PHYSICIAN

CONSENTS

PERMISSION FOR TREATMENT

I HEREBY AUTHORIZE THE JAMAICA HOSPITAL, THROUGH ITS MEDICAL STAFF, TO PERFORM OR HAVE PERFORMED, UPON THE PATIENT WHOSE NAME APPEARS HEREIN, SUCH MEDICAL AND SURGICAL SERVICES, SURGICAL OPERATION AND/OR OTHER PROCEDURES OR THERAPY UNDER ANESTHESIA OR OTHERWISE, AS MAY BE DEEMED NECESSARY IN RELATION TO EMERGENCY TREATMENT ON THIS DATE.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

ARANTEE OF PAYMENT

FOR AND IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE HEREIN NAMED PATIENT, I DO HEREBY GUARANTEE TO PAY THE JAMAICA HOSPITAL, THE FULL AND ENTIRE AMOUNT OF ANY AND ALL BILLS RENDERED FOR SAID TREATMENT.
I HEREBY AUTHORIZE THE HOSPITAL TO RELEASE ALL MEDICAL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TREATMENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

AUTHORIZE OF PAYMENT

EREBY ASSIGN, TRANSFER AND SET OVER TO THE JAMAICA HOSPITAL SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM THE GOVERNMENT AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT.

PATIENT/RELATIVE OR GUARDIAN

SIGNATURE

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

WITNESS

SIGNATURE

PRINT NAME

DATE

FORM NO. J00018-2C

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y
ADM: 10/31/2009 081X
STAFF, PHYSICIAN 01 130381015

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed on the back of this form, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the hospital, its staff, and the facilities listed at the back of this form.

Signature of patient or authorized representative

Relationship to patient

Date

AFFIRMATION OF PRIOR RECEIPT

By signing below, I acknowledge that I have already received a copy of the Notice of Privacy Practices, and have given my consent for the use of my health information for the purposes noted above. I do not wish to receive another copy of the Notice Privacy Practices at this time.

Signature of patient or authorized representative

Relationship to patient

Date

THIS FORM IS PART OF THE MEDICAL RECORD

M00011 9/06

JAMAICA HOSPITAL MEDICAL CENTER

Jamaica Hospital Medical Center
8900 Van Wyck Expressway, Jamaica, New York 11418
Telephone # 718 206-6000

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, heath maintenance organization, self-insurance plan, governmental program, or other payer ("Heath Plan") for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint JAMAICA HOSPITAL MEDICAL CENTER ("Health Care Provider"), located at 8900 VAN WYCK EXPRESSWAY, JAMAICA, N.Y. 11418 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.

Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name this ___ day of _____, 200 __.

YOU SIGN HERE: _____

PRINTED NAME: SCHOOLCRAFT ADRIAN

ADDRESS: _____

MEDICAL RECORD # 1298984

WITNESS: _____

PRINT NAME/TITLE: _____

ADDRESS: 8900 Van Wyck Expressway, Jamaica, New York 11418

Form No. J00023

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOLCRAFT, ADRIAN
1298984 M DOB: 06/21/1975 34Y F/C: 01
ADM: 10/31/2009 23:03 081X 130381015
STAFF, PHYSICIAN

ACKNOWLEDGEMENT OF THE REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS TO BE SIGNED BY THE PATIENT.

In order for a provider to appeal a health plan's payment denial for a patient's treatment, the patient must sign and date the following consent to the release of medical records. A certified external appeal agent assigned by the New York State Insurance Department will use this consent to obtain the patient's medical information relating to the external appeal request from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I SCHOOLCRAFT ADRIAN, acknowledge that my health care provider may request or is requesting an external appeal because of a retrospective adverse determination of my health plan. I authorize my HMO, insurer, or provider to release all relevant medical or treatment records, including my name and other personal identifying information, date of admission, assessment results and history, summary of treatment plan, progress and compliance, treatment recommendations, any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, related to my provider's external appeal, to the external appeal agent. I authorize the external appeal agent to use this information solely to make a determination on my provider's appeal.

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in regulations. I understand that information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations, however, state privacy protections may still apply. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, by contacting the New York State Insurance Department in writing.

This release is valid for one year from _____ (today's date).

_____
Signature of Patient (or legal representative) (Date)

_____
Description of legal representative's authority to act on behalf of the patient.

Patient's Health Plan ID#: _____

If you have any questions contact the New York State Insurance Department at: 1-800-400-8882 or visit our Web site at www.ins.state.ny.us.

Form No. J00027

PATIENT HISTORY REPORT

Jamaica Hospital Medical Ctr
Department of Clinical Laboratories
8900 VanWyck Expressway, Jamaica, NY 11418
Pathologist Name, Medical Director

PATIENT: SCHOOLCRAFT, ADRIAN
MRN#: J1298984
ADMIT: 10/31/09
Loc/Rm/Bed: J081X--
DOB: 06/21/1975 AGE: 34 SEX: M
ADM: ,
ACCT#: J130381015

H E M A T O L O G Y

	D1010449-M1		
COLLECTED	11/01/09 00:12		REFERENCE RANGE
PRIORITY, PHYSICIAN	STAT NWAISHIENYI, SILA		
C B C			
WBC	*12.3	H	4.8-10.8 K/uL
RBC	*5.02		4.50-5.90 M/uL
HGB	*14.8		14.0-18.0 g/dL
HCT	*44.0		42.0-52.0 %
MCV	*87.6		80.0-94.0 fL
MCH	*29.4		27.0-31.0 pg
M	*33.6		32.0-36.0 g/dL
MPV	*8.5		7.2-10.4 fL
RDW	*13.7		11.5-14.5 %
Platelet Count	*251		130-400 K/uL
Smear Review:	*Completed		
M1: Troponin was cancelled on 11/01/2009 at 00:12 by HIS; KEANE HIS# 2			
ORDERED			
KEANE			
Neutrophils Auto	*82.4	H	44.0-80.0 %
Lymphocytes Auto.	*11.0	L	13.0-43.0 %
Monocytes Auto	*5.7		2.0-15.0 %
Eosinophils Auto.	*0.2		0.0-3.0 %
Basophils Auto.	*0.7		0.0-3.0 %
Segs, Absolute	*10.1		2.1-8.6 K/uL
Lymphs, Absolute	*1.3		0.6-4.6 K/uL
Mo s, Absolute	*0.7		0.1-1.6 K/uL
E Absolute	*0.0		0.0-0.9 K/uL
Basos, Absolute	*0.1		0.0-0.4 K/uL
Absolute NRBC Instrumen	*0.00		None %/100 WBC
Smear Review	*Agree w/Auto		
M a n u a l D i f f e r e n t i a l			
Nucleated RBC	*0		None /100 WBC
NRBC Absolute	*0.00		None K/uL

* - RESULT REPORTED FIRST TIME KEY FOR ABNORMAL COLUMN: L-LOW, H-HIGH, AB-ABNORMAL, P-PANIC

PATIENT HISTORY REPORT

Jamaica Hospital Medical Ctr
Department of Clinical Laboratories
8900 VanWyck Expressway, Jamaica, NY 11418
Pathologist Name, Medical Director

PATIENT: SCHOOLCRAFT, ADRIAN
MRN#: J1298984
ADMIT: 10/31/09
Loc/Rm/Bed: J081X--
DOB: 06/21/1975 AGE: 34 SEX: M
ADM: ,
ACCT#: J130381015

C H E M I S T R Y

	D1010449-M1	
COLLECTED	11/01/09 00:22	REFERENCE RANGE
PRIORITY, PHYSICIAN	STAT NWAISHIENYI, SILA	
Glucose	*94	74-106 mg/dL
BUN	*14	9-20 mg/dL
Creatinine	*1.0	0.7-1.3 mg/dL
Sodium	*138	137-145 mEq/L
Potassium	*4.1	3.5-5.1 mEq/L
Chloride	*104	98-107 mEq/L
C	*24	22-30 mEq/L
Calcium	*9.4	8.4-10.2 mg/dL
Protein	*8.2	6.3-8.2 g/dL
Albumin	*4.7	3.5-5.0 g/dL
Bilirubin (Total)	*0.6	0.2-1.3 mg/dL
ALT (SGPT)	*51	21-72 U/L
AST (SGOT)	*46	17-59 U/L
Alkaline Phosphatase	*57	37-126 U/L
Lipase	*55	23-300 U/L
Anion Gap With K	*14.10	mmoL/L
Anion Gap	*10.00	mEq/L
Amylase	*44	30-110 U/L

M1: Troponin was cancelled on 11/01/2009 at 00:12 by HIS; KEANE HIS# 2
ORDERED
KEANE

* - RESULT REPORTED FIRST TIME KEY FOR ABNORMAL COLUMN: L-LOW, H-HIGH, AB-ABNORMAL, P-PANIC

SCHOOLCRAFT , ADRIAN

JAMAICA HOSPITAL MEDICAL CENTER
8900 Van Wyck Expressway Jamaica, NY 11418

FACE SHEET

3/22/10

PATIENT

ACCOUNT NUMBER	MEDICAL RECORD NUMBER	ADMIT DATE & TIME	BAR CODE-MEDICAL RECORD NUMBER
130381874	1298984	11/03/2009 15:00	

LOCATION	FIN CLASS	SOURCE	TYPE	DISCHARGE DATE & TIME	BAR CODE-ACCOUNT NUMBER
03MH 9HAL 01	19	7	P	11/6/09	

LAST NAME	FIRST NAME	M.I.	AKA	VETERAN
SCHOOLCRAFT	ADRIAN			N

DATE OF BIRTH	AGE	SEX	REL.	MAR ST.	RACE	PLACE OF BIRTH	LANGUAGE	INTERPRETER NEEDED
06/21/1975	34Y	M	NO	S	W	NY	ENG	N

ADDRESS	CITY	STATE	ZIP
82 60 88 PL	RIDGEWOOD	NY	11385

TELEPHONE NUMBER	OCCUPATION	SOCIAL SECURITY NUMBER
(718)570-6224		***-**-****

EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
UNKNOWN					(999)999-9999

NEXT OF KIN	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
SCHOOLCRAFT, SELF	09	82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMERGENCY CONTACT NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER
SCHOOLCRAFT,	*09*		(718)570-6224

MEDICAL

ATTENDING PHYSICIAN / CODE	PVT./SERV.	OTHER PHYSICIAN / CODE	MEDICAL SERVICE
HOVANESIAN, SHUSHAN 5904	S	,	PSY

ADMITTING DIAGNOSIS	ICD-9-CM CODE
PSYCHOSIS NOS	298.9

ADMITTING PHYSICIAN / CODE	NEWBORN WEIGHT	RESERVATION DATE & TIME	TEAM COLOR
HOVANESIAN, SHUSHAN 5904		11/03/2009 15:00	

GUARANTOR

GUARANTOR NAME	RELATIONSHIP	OCCUPATION	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01		999-99-9999

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
82 60 88 PL	RIDGEWOOD	NY	11385	(718)570-6224

EMPLOYER	ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
UNKNOWN					(999)999-9999

INSURANCE

PLAN CODE / PRIMARY INSURANCE	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER
AETN AETNA US HEALTHCARE	BBM6PBBA	US0080410090	PENDING

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER
PO BOX 981109	EL PASO	TX	799981109	(800)451-8843

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SCHOOLCRAFT, ADRIAN	01	06/21/1975	***-**-****

SECONDARY CARRIER	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER
,			

TERTIARY CARRIER	POLICY NUMBER	SEQ. / GROUP #	AUTHORIZATION NUMBER

ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER

SUBSCRIBERS NAME	RELATIONSHIP CD	DATE OF BIRTH	SOCIAL SECURITY NUMBER
,			

DATE OF PREVIOUS HOSPITAL ADMISSION	FACILITY NAME	ADMITTED BY
	UNSPECIFIED	n09ad

FORM NO. M00001
JHMC 78

./13/2009 **UIS Data System** Page 1 of 1

amaica Hospital **Attestation Statement** Coder: vdorch
Medical Center

Patient Ctrl Num / Medical Rec Num	Patient Name	Age / DOB	Admit Dt/Hr / Discharge Dt/Hr	Exempt IPC	Gend	Admit Source / Disposition
130381874	SCHOOLCRAFT, ADRIAN	34	11/03/2009 15		M	7 - ER
1298984		06/21/75	11/06/2009 14			01 - DC Home

Payors

Primary: HMO INSURANCE

ALC Days: 0 Acute Days: 3
ALC Type: Leave Days: 0
ALC Date: LOS: 3

ATTENDING PHYSICIAN: 003819 ISAKOV, ISAK LIC#: 00220352

Admit DX: 2989 PSYCHOSIS NOS Cause DX:
Prin DX: 30924 (Y) ADJUSTMENT DIS W ANXIETY Place DX:

Secondary DXs (PoA)

DRG Information

DRG: 427 NEUROSES EXCEPT DEPRESSIVE
MDC: 19 MENTAL DISEASES & DISORDERS
NYS Version: 026

Short Trim: 2 Long Trim: 11
Weight: 0.73860 Avg LOS: 5.0

(Base)	+	(ALC)	=	Total
$3,693.00	$0.00			$3,693.00

PROCEDURE	DATE	SURGEON	
1 - 9438 SUPPOR VERBAL PSYCHOTHER	11/03/2009 -- 003819	ISAKOV, ISAK	LIC #: 00220352
2 - 9425 PSYCHIAT DRUG THERAP NEC	11/03/2009 -- 003819	ISAKOV, ISAK	LIC #: 00220352